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SADISM AND MASOCHISM IN HUMAN CONDUCT

DR. ANGEL GARMA
Member of the Argentine Psychoanalytic Association

TRANSLATED FROM THE SPANISH BY SAMUEL B. KUTASH

PREFACE

The human ego apparently constitutes an entity. It strives to coordinate mutually antagonistic drives and to reconcile discrepancies which exist in the psychic apparatus. In this activity it allows itself to be guided by well-defined general purposes which furnish it with principles of conduct.

Undoubtedly, one of these principles is that of lending a pleasing aspect to the life of the individual, constantly seeking that which produces satisfaction. In psychoanalytic terminology, this behavior is described by stating that the ego obediently conforms to a principle of constantly seeking pleasure and avoiding pain.

In addition, it is known that the predominance of the pleasure principle in the ego is not always possible in the environmental circumstances in which the human being must develop. The external environment imposes exigencies on the ego which force it to inhibit its drive toward immediate satisfaction. It thus has to subordinate itself to the important reality principle and even if it does not abrogate the pleasure principle, at least, it must curb it somewhat in its capacity for realization.

The search for pain, natural or foreign, does not appear to be one of the general purposes of the ego. Nevertheless, a sincere examination of individual and social life reveals the existence of much more pain than that which could have been brought about by the inhuman vicissitudes of life.

Freud had insisted that such unnecessary pain frequently occurred. He explained it as something sought for by man himself and motivated simply by the satisfaction of enduring it. This statement by that emin-

ent man of science has been regarded with incredulity even in psychoanalytic circles. This state of affairs results from the fact that, in his psychic foundation, each individual is the product of his infancy and closes his eyes, through the medium of repression, to that which causes him unpleasantness.

It certainly takes some effort to be able to accept the existence of this phenomenon in mankind. But to deny the production by man of unnecessary pain and pain without any benefit to the individual is merely a negative illusion. It represents an attempt to satisfy a drive, in fantasy, which is not confirmed by the data of reality.

If it had no more transcendency than to silence a displeasure, such a calming illusion had ought to be well received. But its approbation is not innocuous and must struggle against the whole personality guided by a drive for seeking greater well-being for its fellow creatures and itself. The disagreeable phenomena, which this illusion covers up, do not prevent it from existing and producing consequences by the mere deed of being repressed.

It is more useful to mankind and cultural progress to follow the road of discovering the hidden individual tendencies which conspire against the conscious drives for pleasure. Only in this way can these tendencies be mastered so that we can be on our guard against them and orient them toward more useful purposes.

For the same reason, it is necessary for us to have the courage to admit that in addition to the love instincts there exist the death instincts to direct the human being's activities. These death instincts which are intermingled with the love instincts, give rise to the sadistic and masochistic psychic phenomena. From their consequences it must be surmised that these manifest perversions are their external evidences on less frequent occasions, but that they have much greater importance in other complex phenomena where they cannot be so easily isolated as the motivating forces.

This attestation justifies the present monograph, which proposes to search for hidden sadism and masochism and to analyze out the complicated phenomena which might mask them. Wars, suicides, the obsessive neuroses, and the analysis of a famous artist will furnish us with four useful vantage points from which to localize the death instinct in the human unconscious.

Flavit et dissipati sunt is the motto which Freud presented to psychoanalytic investigation in order to demonstrate that by examining into dreaded phenomena, real or apparent, danger is driven away. Even though this does not occur with the simplicity with which the famous maxim appears to indicate, we should heed its implications, always guided by the drive toward finding a better future, free from the instinctive complications of the present which are pernicious for mankind.

ANGEL GARMA

Beunos Aires, April 1943

Chapter I

Wars

Aussi bien que la paix la guerre a ses douceurs. (*Chénier*)

How are wars currently explained? In present times, when economics is of great importance, one of the preferred explanations centers around the economic life of the peoples. It is commonly asserted that nations fight in order to defend their own wealth or to take the possessions of other nations for themselves. At other times, wars were explained differently and were attributed to such factors as wounded national pride or differences in religious belief.

There is no doubt that economic factors enter into the genesis of wars and that explanations of this type have persuasive force. Nevertheless, the fact that wars have occurred among savage as well as civilized peoples, and that in those conflicts, none of the combatants were motivated by the desire to gain economic advantages, appears to demonstrate that there is no reason to consider economics as the only motivating factor in warlike undertakings.

The primary factor in the causation of wars appears to be the same as that which occasions a dispute between any two individuals. It is a biological psychic factor known as human aggressiveness. There are aggressive instincts inherent in all mankind and it is these which impel men to fight. This human aggressiveness which is socially controlled in tranquil periods, always selects an appropriate time to manifest itself when a series of circumstances, conducive to its expression, have accumulated. These circumstances can be economic in nature, matters of national pride, or ideological differences concerning the structure of the State, etc., and then the latent aggressiveness comes out of its hiding place to freely express itself in all its horrible dimensions.

The existence of such latent aggression is not a pleasant factor in human relations. For that reason, constant efforts are today made to repress it, as much in individuals as in peoples. There are men who have many aggressive tendencies and others who have very few. In terms of popular psychology, the former are called "bad" men and the latter are known as "good" men. But our eagerness for an understanding of this

phenomenon is not even remotely satisfied by this classification. The question arises whether the bad men have been so from birth because they possessed intense aggressive instincts of hereditary origin or whether, on the contrary, they were born good and were then perverted by the social environment in which they had to live.

The second theory, namely, the one which postulates the congenital goodness of man, sounds more pleasant. According to it, badness exists in the world because the social environment adversely influences the development of the human spirit. This is undoubtedly looked upon as a desirable theory. According to it, man is basically endowed with a white and angelical soul which persists in all circumstances even though it is more or less covered by cloaks of badness which society has forced upon it.

When this theory is publicized, its ready acceptance by the public is completely assured. Who, for example, has not seen certain theatrical or cinematographic works in which delinquent children are portrayed? These works usually depict these children as having committed a crime because of having lived in a cruel environment which has perverted them. Arrested, the children are committed to a reformatory and are so mistreated there that their moral perversity is still further reinforced. But a happy day brings an intelligent modern educator to the institution. He substitutes kind methods of treatment for the cruel, inhuman ones, and all the badness miraculously disappears. The incorrigible minors are converted into well-educated, affectionate, and socially useful children.

At other times, in literary works, cases are described of violent, insane people who were brought to their sad condition because they had been maltreated by persons in their environment, and who are cured and rescued from their insanity, when they are situated in a more pleasant environment. On still other occasions, one runs across political creeds which affirm, for example, that the origin of human badness resides in individual habit or in the principle of ownership and that if these did not exist, wars would be exterminated and social well being would reign in the world. Don Quixote said something analagous to the above in beautiful language when, in the midst of the shepherds, taking a handful of acorns in his hand, he recalled the happy times when "the words *yours* and *mine* were non-existent." According to Don Quixote "all was then peace, all amity, all concord."

There is no doubt that such a theory fires the spirit and gladdens the soul. Yet, in spite of this, the probability is that the theory is erroneous. There is nothing to prove the non-existence of congenital "badness" in man. Observations made on both children and adults, appear to demonstrate the very early existence of intense aggressive instincts, whose development has not been motivated by the environment in which the individual found himself. Although the currently expressed view that society adversely conditions man may have some truth in it, the conclusion is not thereby justified that man, if left to his natural evolution, would be converted into a completely kind, altruistic and amiable being.

The theory under discussion and its literary and ideological reflections are illusions which have their basis in the widespread tendency to repress and ignore something disagreeable. That something is human aggressiveness.

Ethnology and psychology permit us to infer that, from the time of the earliest existence of the human species, man was one of the cruelest of all the living beings who inhabited the earth. He never even respected his fellow creatures, in contrast to what happened in the animal species. If man is not that way now, it is because cutural evolution, over thousands of years, has come to dominate and inhibit his aggressiveness, by modifying the psychic apparatus of the individual.

How did such cultural evolution take place? If we desire to picture man to ourselves as he was in the earliest times of his existence, we must admit that his aggressiveness was freely manifested. In primitive man, moral restraints, which now serve to control the individual when he is thinking of committing an evil deed, must not have existed. In those days, the only psychic deterrent to aggressiveness must have been the tendency for love or kindness toward the other person and thus, then as now, pain was felt when harm was done to some loved one. But, primitive man surely did not hesitate to injure anyone who was vexatious and indifferent to him, if his strength permitted it.

Darwin, and other investigators, assume that the earliest communities that existed, must have been composed of a group of individuals dominated by the strongest one among them. In other words, according to Darwin, people, in those days, lived together in a congregation ruled by a powerful chief, who enjoyed all the powers, and the members of this group of individuals submitted to the chief. How was this situation

changed? Ethnological and psychological data confirm the following hypothesis concerning the change in the primitive social structure. All the facts lead us to believe that the weakest and most submissive individuals banded themselves together and, by common consent, set themselves the task of killing the powerful chief. This they achieved by uniting all of their strength. And, once the chief had been assassinated, the triumphant ones, according to Freud, were obliged to celebrate their victory in a cannibalistic orgy, by devouring the corpse of the chief.

Thus, a new social situation arose. But there was one danger, namely, that one of the triumphant ones, stronger or more intelligent than the others, would attempt to impose himself on the others. If this happened, there was a return to the previous situation, something which the majority did not want.

There was only one means of avoiding this possible danger. It was, simply, that the victors over the old chief should persist in their coalition and put down all attempts at individual supremacy. When this stage was reached, there originated what can be called a community of brothers. In it all individuals were, in a certain measure, equal. And if the community decided to elect a chief, he still did not have the abundance of powers and rights which the old chief had.

In this community of brothers individual aggression within the group could not be sanctioned because it weakened the cohesion among the individuals, and the group had to mantain unity in order to be able to continue its existence in the new social form. Such a necessity naturally had to bring with it the establishment of laws or taboos to hold individual aggressiveness in check.

One of these taboos was probably that of endogamy. It was required that an individual must seek his future wife outside the group in which he lived. With this provision, it developed that the women of the individual's own group, those who were seen by that person every day and were, in a sense, sacred for him, were not obliged to excite in him, the emotions of love or the rivalries that love brings with it.

Another way of suppressing individual aggression within the group must have been by deflecting it toward the exterior. For this purpose, an external enemy, such as a neighboring tribe, was sought out, and a struggle was fought against this enemy. This served to still further unite the members of the same group. In this way, the existing aggressiveness within the group, was drained off into external channels without injuring the internal unity and cohesion of the group.

In this phase of cultural evolution there were, therefore, external struggles against neighboring tribes rather than internal conflicts between the individuals of a group. In other words, what we now call wars existed even in those times. It is this type of primitive social organization of aggressiveness which still persists in period of war in modern times. In effect, the nation or nations which wage aggressive wars against other nations, constitute groups of individuals who can satisfy their aggressiveness by directing it aganst the enemy since they are, at the same time, severely prohibited from expressing the aggression within their own group.

It would be well, at this point, to leave aside for a moment the study of aggressiveness and to examine other psychic phenomena which also influence the causation of wars. These other phenomena are discussed in what follows. Odd as this may seem, there exist in all human beings not only aggressive impulses but also tendencies to seek pain itself.

It would be easy to present a series of clinical cases to confirm the above thesis. But we will limit ourselves to citing only one. It is the case of a neurotic woman, who, in the course of psychoanalytic treatment, related the following infantile memory. One day she went to the dentist's office in order to have him extract a tooth. The dentist accomplished the extraction without the use of anesthesia, an occurrence which would certainly not have produced great pleasure to any normal person. But to the patient, according to her own words, the operation was so pleasing that she returned the following day so that the dentist could pull out another tooth which did not bother her in the least. And she wanted to go back even a third time for the same purpose but her mother prevented her from doing so, on being told about her abnormal conduct.

The study of patients such as the one cited has enabled the psychoanalyst to describe and recognize the tendency to self-punishment which was already previously perceived faintly as a result of the investigation of sexual perversions of the masochistic type. The psychoanalyst has also been able to verify that this strange phenomenon is even present in normal individuals but to a lesser degree. Patients of the type cited, in presenting their exaggerated desires for suffering, are like caricatures in which normal lines appear in exaggerated emphasis. But for psychological study they have the advantage of displaying in more obvious form what passes unnoticed in normal cases.

In our discussion of aggressive drives, we raised the question of whether they were congenital or created by the unfavorable influence of the environment. The same problem also arises concerning the desires for suffering, and various opinions can be presented to defend each one of several possible solutions. The most satisfactory answer is that drives toward suffering should be considered to be congenital instincts which can be reinforced by external environmental circumstances during the life of the individual.

Psychoanalysis postulates the existence of two distinct compartments in the human mind. One of these is small and presents the peculiarity that the individual is aware of and accounts to himself for what occurs in it. For these reasons, it is designated by the term, *conscious psychic system.* The other compartment is much greater and can only be known indirectly. When the eyes are closed to the external world and we attempt to see what occurs within us, our internal vision does not comprehend or become aware of what takes place in that compartment. It is thus designated as the *unconscious psychic system* (not subconscious).

Well now, the human instincts – and among them the aggressive drives and those toward suffering, which psychoanalytic investigations have designated sadism and masochism – proceed from the unconscious compartment and then pass into the conscious. But this is not always possible because in the process of passage from one compartment to the other, there is encountered a psychic force which acts like a rigorous gate-keeper, with the purpose of not allowing anything which is disagreeable to the *ego* of the individual to pass. The painful or disagreeable material is retained in the unconscious department; in psychoanalysis it is then said to have been *repressed.*

That is what usually happens with the aggressive instincts and the drives toward suffering. They are in great part repressed. But it must be understood that the instincts are something vital and alive and that they are not destroyed simply because they are repressed. Even after an intense repression they are continually striving to free themselves from their hiding place and they attempt to inveigle the individual into situations in which there is no way out but to satisfy the instinctual desires.

According to an old Arabian tale, there was once a servant in Damascus who wished to escape death. On a certain occasion, this servant, trembling with emotion, told his master about a story that had filled him

with fear. During the night, he had dreamt that Death was to await him on a predetermined day in the market-place of Damascus. For that reason, in order to avoid the dangerous meeting, the servant asked the permission of his master to travel to Mecca on that fateful day. And that is what he did. But when he arrived at Mecca, he was met there by the very Death which he tried to avoid and then he remembered that the place about which he dreamt was not Damascus but Mecca. He was thus mistaken about the place in the conscious remembrance of what he dreamt. But still it was too late to repair his fatal error and Death accomplished its mission. It is worth saying that the servant had unconscously gone in search of Death.

Something analagous to the above occurs with the repressed instincts. They impel the individual to be placed in situations in which they can express themselves or become satiated. That is to say, they unconsicously cause man to seek situations in which he has no choice but to be aggressive or in which he must find grief and suffering. And one such a sought-for situation is war.

In summary, wars occur, not only because man has aggressive instincts, but also because he unconsciously seeks suffering. And notwithstanding the criticisms which it is anticipated the following statement will occasion, it can be said that the aggressive tendencies as well as the desires for suffering enter into the causation of human conflicts. Human sadism and masochism are the causes of war.

There is still a third factor which must be considered in the causation of wars. As has been demonstrated by psychoanalysis, the idea of their own death is strongly repressed by all individuals even when the idea occurs to them. So much is this so that many savage peoples appear to ignore, at least in a conscious manner, what natural death signifies. For them death is always a consequence of fortuitous accidents which happen to the individual and they believe that without such accidents man would continue to live eternally.

The primitive man considers himself immortal. Only through observation of the deaths of other persons or of other living beings, does he secondarily believe in the idea of his own death. For the civilized man also, the idea of his own death has only scanty conscious psychic overtones. Therefore, when a war begins, individuals do not think seriously, with the intensity that they should, concerning their own possible sad end in the course of the conflict.

The existence of this factor explains the little interest on the part of most people in avoiding a war which can be fatal for them. The repression of the idea of their own death explains the feeling of tranquillity and, in some cases, even of jubilation, with which people usually receive the news of the declaration of war.

The fear of death usually presents itself later, after deaths and wounds have been observed at first hand, after falling bombs and exploding bullets have been directly experienced, and after a series of privations and physical pains and moral griefs have been suffered.

The disbelief in the possibility of self-death and the presence of sadistic and masochistic instincts all create the psychological situation in which wars originate. To these essential factors are added secondarily, certain propitious circumstances, such as the drive for power, wounded national honor, the need to better the country's economy, vital space and many more. The circumstances mentioned can have a decisive importance in determining the moment when the war begins and in influencing its duration and its course, but are not the underlying primary factors which explain why wars occur at all.

We are indebted to Freud for an ingenious theory which explains the formation of the instincts. According to him, when life originated, or in other words, when for the first time and through a process which we disown, inorganic matter was converted into organic matter, two distinct tendencies were created in the womb of this primitive organic substance. One was the drive to return to the previous state, that is, the tendency to again become converted into lifeless matter. The other was the drive to continue the vital progression, to grow, develop and unite with other organic beings to produce each time more complex entities. This last drive Freud compared to what Plato designated with the name of *Eros*, the tendency which tries to re-unite the organism with other living beings. To the first tendency which seeks the cessation of life, Freud gave the name of the *death instinct* or *Tanatos*. From the instinct of death is derived the *instinct of destruction* which can be directed towards the exterior or even against the individual himself. Thus originate the aggressive or sadistic instincts and the suffering or masochistic instincts which enter into the origin of wars and other individual and social events.

These primary instincts persist in all living beings. They never present themselves in pure form but rather in association with each

other thus giving origin to various types of manifestations of life and death.

Culture is the work of the erotic instincts in the platonic sense of the term. The Eros makes efforts to join men together thus creating superior types of communities. The instincts of death and destruction work in opposition to this constructive instinct thus creating obstacles to cultural evolution.

It is interesting to further explore the ways in which these psychic factors, which are so essential in causing wars, are actuated. Principally, the manner in which sadism and masochism are set into motion must be further elucidated and why the third factor, the lack of belief in self-death, operates only by removing obstacles to the exteriorization of the other two, should be clarified.

Sadistic impulses not only cause wars but also enter into other social manifestations. At times they appear in almost pure form as in the case of the prize-fights of the ring, bull fights and religious or racial persecutions which humanity practices from time to time. At other times their manifestations are much less obvious. The fact that there is a great quantity of unnecessary pain in human relations and that it occurs only because it satisfies human aggressive instincts and impulses toward suffering of unconscious origin, must be taken into account. If society has not yet overcome many of the obstacles which have been interposed in its search for well-being, it is not because it is impossible to do so but rather because, unconsciously, it has no desire to remove them so that human pain can continue to exist. This is a melancholy conclusion, especially for persons who are animated by a fervent eagerness for social improvement and by a zeal for mutual aid. The actual life experiences, accelerated as they are, in periods like the present when mankind is passing through a phase of cruelty, tend to confirm the conclusion stated above and to demonstrate the truth of the well-known phrase: *homo homini lupus.*

Normally, the sadistic impulses are held in check by that psychic importunity known by the name of conscience which does not permit the individual to do "what his inclinations make him do" as the saying goes. "Conscience makes cowards of all of us," exclaims Hamlet. And thus it happens in real life. Conscience even goes further than that. In its actual solicitude for moral perfection, it exhorts us to even love our enemies but in this last respect its mandates are not usually followed.

There is a well-known proverb: "he who robs a thief, has one hundred years of absolution." What is the significance of this proverb? Although to rob is in itself something bad, if it is a thief that is robbed, the situation is already different and the conscience has no right to protest. In that case the robbery appears to be something that is permitted. Thus, the conscience is at times deceived.

The same type of phenomenon, as occurred in the proverb with the impulse to rob, happens in the case of sadism. In effect, it is usually expressed under the protection of a moral motivation. For example, when some governor of past centuries, imprisoned and martyred a political enemy, it is possible that he did so thinking that he was, in that way, caring for the welfare of those he ruled over, and he was not conscious of the fact that, at the same time, he satisfied his own hatred and aggressive impulses. That is what happens in many other analogous situations, past and present.

What is it that happens in wars? Here too, the liberation of the sadistic instincts from the yoke of the conscience takes place under the protection of some moral motive. The combatants believe that they fight to defend their wounded national honor, to impose their religion on godless peoples, or to free themselves from the oppression of an enemy nation. But they are not consciously aware of the fact that their sadistic and masochistic instincts are satisfied in war.

In spite of what has been said, there is no reason to believe that only the above-mentioned motivations intervene in wars. There are also important motives of a nationalistic type such as those which oblige an attacked nation to free itself from unmotivated aggression in the same way that an individual, assaulted in a lonely place, is put in the position of fighting to overcome his attackers. In such a case, the attacked nation sets free – and it must do so as intensely as it can – all its own aggressive instincts which up to that time had followed other channels or were in a latent state. Not even in periods of international calm can we deny the truth of the proverb: *si vis pacem, para bellum.*

How can wars be avoided? Here, arises the vision of pacifism with all its charms. But they are deceitful charms. Yet it is only a few years ago that mankind lived in a period of pacifist clamour. The entire world, at that time, cried out against wars and everybody exalted the idea of fraternal love among nations. And, in spite of all this, almost without a transition, the actual tragedy of war has succeeded that pacifism. How has this been possible?

That abrupt change is really not so strange. Psychologically, it can be demonstrated that pacifism and wars are two phenomena which, in part, originate from the same source.

There exists a psychic illness, which we will study more closely later on, the obsessive neurosis, in which the patients frequently have an exaggerated compassion which manifests itself in excessive solicitousness for the welfare of others. They are individuals who are easily moved by another's pain, who have ready tear and who frequently protest against the cruelties of life. Some of their obsessive acts have the purpose of avoiding, if possible, misfortunes to their fellow-creatures. If such patients see a stone in the road, even though it may be a small one, they think that an auto passing through at an excessive speed could get into an accident. Then they feel the imperative obligation of removing the stone, which had stimulated these reflections, from the road. When these individuals are subjected to psychoanalysis, though they give the first impression of being such good people, they invariably are found to possess, in their psychic apparatus, intense sadistic tendencies and desires of causing harm to others. Their exaggerated compassion is a psychic attempt to overcome their aggressive impulses. It is a phenomenon which is known in psychoanalysis under the name of *reaction formation.*

Current pacifism has, in part, an analogous origin. It is a reaction formation designed to cover up latent sadistic desires. This explains to us the limited efficacy of pacifism and the ease with which a pacifistic people can be converted rapidly into a people full of intense warlike impulses. To cite only one example from the present day, it is enough to recall that the most successful pacifist novelists in recent years have almost all been of German origin and that their greatest success occurred in Germany itself.

It is not pacifism or the denial of the existence of human sadism and masochism, as inbred factors, which is going to save humanity from the calamity of war. It could not even do so if its teachings were applied in the earliest years of the growing individual, for example, by preventing children from having lead soldiers or from playing soldiers. Wars will only disappear when human sadomasochism is very clearly understood and mankind has learned how to channelize it in non-pernicious actions and in useful deeds, resulting in what psychoanalysis knows under the name of *sublimation.* Then and only then will the existing dis-

cords between men, which now result in wars, be solved by more rational means than through armed struggles and there will be less grief on the earth. However, this beneficient solution will probably only be reached in the dominions of Utopia.

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Chapter II

Suicides

Why do you, man, when you speak of something, continually say: this is good, this is bad? With that, have you explored the intimate connections of the act? Do you know with certainty how to explain the reasons for its occurrence, why it had to happen? If you achieved this goal, you would not send forth your judgments with such great levity.
(*Goethe*)

Suicide is a psychological phenomenon provoked by a variety of factors, among which can be distinguished those of an environmental nature. In fact, statistics clearly show that the number of suicides increases and decreases in response to successive occurrences in the social environment and family background of the individual. How does this happen?

The Loss of the Libidinous Object

Suicidal cases are frequently described which are precipitated by a serious economic loss or by the death of a beloved individual. What is the psychology of these suicides?

The death of a loved one or economic reverses are felt by the individual as irreparable losses. For that particular individual, life lacks interest because he considers himself incapable of satisfying most of his desires. When the interesting or agreeable personality has died, it is not surprising that the person strongly affected by this death thinks of putting an end to his own existence by committing suicide.

Psychoanalytically, this act can be expressed by the statement that the loss of a libidinous object of vital importance is one of the motivations for suicide.[1]

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(1) Various examples of this occur in the literature.

In The Loves of Teruel, by Hartzenbusch third act, scene XI:

Marsilla

The strange grief does not leave me.
With what can one fill the hideous void
which the soul feels, when deprived of its loved one?
Father, without Isabel, for Marsilla,
there is nothing left in the world!
For that reason in my delirious suffering

The suicide wishes to disappear from life in the same manner as his libidinous object has disappeared for him. There exists, in a certain way, an identification with the lost object and also with the fate that befell that object. The identification with a deceased loved one is sometimes

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Note continued from previous page.

barbarous thirst for blood consumes me.
To spill it in rivers to satiate my desire,
And when I have no more to pour,
that of my own veins will my spirit loosen.

In the same work, fourth act, scene X:

Isabel
. . . his unfortunate love is what kills him
Deliriously I said to him: "I hate you";
he believed the sacrilegious word,
And expired with grief.

In Don Alvarez, or The Force of Destiny, by the Duke of Rivas, third act, scene III:

Don Alvarez
Seville! Guadalquivir!
What torments in my mind!
Night in which I saw such an untoward event
My brief fortunes to flee!
Oh! What a burden it is to live!

In Antony and Cleopatra, by Shapespeare, fourth act, scene XV:

Noblest of men, woo't die?
Hast thou no care of me? shall I abide
In this dull world, which in thy absence is
no better than a sty? O, see my women, (Antony
dies.) The crown o' the earth doth melt!
. . . It were for me to throw my sceptre at the injurious gods;
To tell them that this world did equal theirs
Till they had stol'n our jewel.
. . . Then is it sin
To rush into the secret house of death,
Ere death dare come to us?

In the Bible I Kings 16:

15. In the twenty and seventh year of Asa king of Judah did Zimri reign . . .
16. And the people that were encamped heard say: 'Zimri hath conspired and hath also smitten the king'; wherefore all Israel made Omri, the captain of the host, king over Israel that day in camp.
17. . . .
18. *And it came to pass, when Zimri saw that the city was taken, that he went into the castle of the King's house, and burnt the King's house over him with fire, and died.*

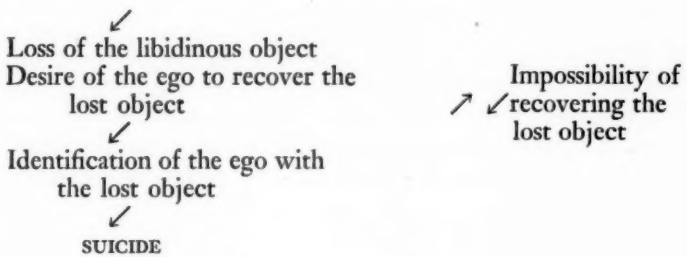
Also in the Bible II Samuel 17:

23. And when Ahithophel *saw that his counsel was not followed,* he saddled his ass, and arose, and got him home unto his city and set his house in order, and *strangled himself; and he died,* and was buried in the sepulchre of his father.

so intense that it can lead to a desire for the same death as that person. This occurs, for example, in the suicide of Melibea in *La Celestina*, by Fernando de Rojas (fifteenth century). The lover of Melibea, Calisto died from a fall while trying to rapidly descend the stairs that would have led him to the domicile of his loved one. Thus, Melibea, on committing suicide, exclaims (twentieth act):

> His death corresponds to mine; give me the strength that it may be soon, without delay; show me that *it has to be by flingng myself down from a height in order to follow him absolutely*.[1]

Summarizing these considerations, psychoanalytically the following diagram can be traced:



Psychology of the Depressive States

Suicide is an act of intense autosadism. The *ego* perpetrates an aggressive act against itself of such strength that it results in self-destruction. We will now study the question of suicide from the point of view of aggression against the self.

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(1) In the following news item published in a periodical on the 23rd of February 1935, the identificatin with the dead loved one can also be observed in the deed of seeking the identical death:

> London, 22. — It has been verified that two North American girls who were despondent because of the death of two English aviators who perished in the aerial catastrophe of Messina, committed suicide. The two girls opened the door of the aeroplane and threw themselves to the ground. The girls had acquired all the seats of the plane and had persuaded the pilot that the door should be closed and the window covered which separated the post of command from the rest of the cabin . . . The sisters had maintained a close friendship with the deputy aviator, H. B., and the official aviator, J. F., who were among the nine dead in the aerial catastrophe in Sicily.

The psychic illness in which the danger of suicide is certainly greatest is melancholia. When melancholic patients are asked about the motives behind their suicidal ideas, they reply that they wish to escape from a disagreeable life by means of death or that they seek to die in order to punish themselves for their many sins. The tendencies of the melancholic patient to aggression against the self are not only manifested in ideas of suicide but also in recriminations which they level against themselves for different reasons.

"Delusional ideas are not lacking in any clear-cut case of melancholia and take the form of economic, physical and psychic destruction". Thus, the patients think "that they have conducted themselves in an unworthy manner, that there is nothing which can save them;" "they involuntarily orient their entire life in the search of their sins; they magnify small faults or innocent actions into great sins." They also believe themselves to be the causes of all of the misfortunes which occur around them. "They imagine that they are to blame for the fact that the other patients are ill, that some one may have died . . . It occurs to them that the whole world must despise them because of their sins . . . They believe that they will be punished in this world and in the other, almost always in some horrible manner".(1)

Freud has shown that the complaints of the melancholic patient represent reproaches that the patient makes against an object which has been introjected into his *ego*. The formula, "self-reproaches are accusations" (*Die Klage sind Anklage*) sums up the conclusions of Freud. In other words, the melancholic, in reality wishes to attack an external object when he directs his aggression against himself.(2)

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(1) Bleuler: *Lehrmuch der Psychiatrie*, 4th edition, Berlin: Springer, 1923, pp. 362.

(2) The most important psychoanalytic works related to the problem of the psychology of melancholia are:

Abraham: *Notes on the Psychoanalytical Investigation and Treatment of Manic-Depressive Insanity and Allied Conditions*. "Selected Papers". The Hogarth Press and the Institute of Psychoanalysis, London, 1942.

Abraham: *A Short Study of the Development of the Libido, viewed in the Light of Mental Disorders*. "Selected Papers".

Freud: *Mourning and Melancholia*. "Collected Papers", Volume IV.

Freud: *The Economic Problem in Masochism*. "Collected Papers", Volume II.

Gero: The Conception of Depression. *Int. Journal of Psychoanalysis*, Volume XVII, 1936.

Rado: The Problem of Melancholia. *Int. Journal of Psychoanalysis*, Volume IX, 1928.

For complete data on this topic in the literature, consult the book of

Fenichel: *Outline of Clinical Psychoanalysis*. The Psychoanalytic Quarterly Library (Published also in *Psychoanalytic Quarterly*, Vol. III ,1934, pp. 91-126.

In order to render this psychological mechanism of melancholia more comprehensible, we are going to illustrate its appearance in various concrete cases. We will follow a line of reasoning a little distinct from that of Freud, but it will lead us to the same goal.

Within the limits of normality there is a psychological state which presents characteristics resembling those which the pathological melancholic state offers. This condition is that of *mourning*; in other words, the state of sorrow in which an individual who has suffered the death of a loved one finds himself.

Let us take as an example, the case of a man who was strongly enamored of a woman who died in an unavoidable accident. This man is in a period of sorrow which is known under the name of mourning. During this time, the *ego* of this man is gradually weakening the intensity of the affective charges which had been directed toward the intrapsychic representation of the loved woman.

This task of weakening the intensity of the affective charges – *the work of mourning*, according to the terminology of Freud – is accompanied by sorrow. The man recalls all of the happy scenes shared with the departed woman and these remembrances make him emotional and cause him to grieve.

In that period of mourning the appreciation of reality becomes partially confused; to the mourner life loses interest, the world seems colorless and even disagreeable. He goes about his business mechanically and attends to his activities like an automaton. At times he evidences aggressive tendencies directed against himself, for example, in the form of desires for death, of causing himself injury by self-mutiliation, of pulling out his hair by the roots or of committing other acts of violence against himself. These auto-aggressive tendencies are clearly observed in the mourning rites for some peoples, for example: cutting the clothes asunder, placing ashes on the head, not washing, etc.[1]

But after a more or less long period of time, the memories originating in the intrapsychic representation of the loved woman lose their

(1) "Rapidly he runs to the sister of the queen. He is dishevelled, pale as a corpse, and *pulls out the hair of his head with the nails and beats his breast with his fists*, flinging himself through the multitude, calling to her who is dying and crying out her name". (Aenied, Song IV, 670.)

emotional power and the grief also becomes less intense. The man finds himself unburdened and free. When this occurs the mourning has accomplished its purpose.

In the psychological complex of mourning for the death of a loved one, there are, thus, four distinct factors.

1. Diminution of the intensity of the affective tendencies directed at the intra-psychic representation of the loved object.
2. Sorrow.
3. Depreciation of reality.
4. Some aggressive tendencies against the ego.

What has just been described is the mourning which can be regarded as normal. Let us now elucidate the significance of melancholia. For this purpose we must assume that the death of the beloved person was, in part, a consequence of an act committed by the *ego*. A case in point, is that of a mother who, because she has not properly cared for her sick child, feels herself to blame for the death of the child. The negligence in the fulfillment of her maternal duties will create a feeling of guilt in her, the intensity of which will depend directly on how great her love for the dead child may have been. This guilt feeling will cause the mother to reproach herself for her conduct with the child, and consequently the mourning of this mother will, in addition to the sorrow of the melancholic patient, present the appearance of the existence of violent self-accusations.

Let us now study the psychological mechanism of *psychogenic depression*. With this end in view, we will briefly describe the psychogenesis of the depression of a patient who lapsed into a depressive state for a period of about one year, and was treated psychoanalytically. One of the main symptoms were his ideas of suicide. He also presented the following symptoms of depression: sorrow, incapacity for work, self-accusations, and ideas of impending physical and moral ruin.

The actual history of the patient was as follows: For years, he had indulged in an intimate amorous relationship with a woman of inferior social status than his own. This amorous attachment, because of the discrepancy in their social situations, had caused him some displeasures. In addition, about one year ago, the woman became ill and her illness was related to her sexual life. Our patient felt himself bound to this woman and morally obligated to continue the relationship in spite of

the social damage it would cause him. However, the patient's love for the woman waned considerably.

Suddenly, and for a number of reasons, the patient's social standing improved immensely. He came to occupy a position of great responsibility and with great social obligations. As a result of this change, his amorous relationship began to be a great detriment to him. He wished to put an end to it but did not do so because he considered himself obligated not to abandon the woman, especially because of her illness. But, at the same time he had guilt feelings in relation to society because of his illicit relationship which was socially disapproved.

In this psychological constellation, the patient sustains various attacks on his professional and social competency on the part of some of his enemies. These frighten him and make him ill with the previously mentioned syndrome of psychogenic depression.

Why is he incapable of defending himself against the attacks of his enemies? A normal individual would easily have freed himself from these attacks and would have achieved a new social triumph. But our patient considered himself incapable of accomplishing this because of his strong guilt feelings.

The psychological process was as follows: his enemies attacked his social integrity and, at the same time, the patient considered himself worthy of reproach for the fact of his relationship with the paramour. In this form, the unconscious of the subject equated the attacks of his enemies with the reproaches which he made against himself. Our patient could not react normally in the fact of the attacks because he actually considered himself to blame for his amorous relationship and this was prejudicial to his social integrity.

We are now going to explain one of this patient's dreams in which this psychological process can be clearly seen. The dream is as follows:

I am looking at a cupboard. A . . . and B . . .approach and question me as to what happened. I am irritated with them, I scream at them violently. I scream at them so much, that they have to call a person whom I cannot make out so well. At this moment I think of D . . .(his paramour), *I feel very sad and cannot continue speaking.*

A . . . and B . . . are the two persons who were most prominent in the attacks on the patient. In view of this fact, the dream is perfectly

comprehensible. The patient desires to free himself from these people; but thinking about his paramour causes him not to be able to defend himself and makes him feel extremely sorrowful.

We will now repeat, by way of summary, the mechanism of the depression of the patient:

1. An ambivalent amorous relationship which is inexpedient for the *ego*.

2. A social triumph which still more intensifies the ambivalence of the amorous affair causing guilt feelings in the patient: (a) in relation to society because of the social inequality between the subject and his paramour, and (b) in relation to the woman, because of her illness.

3. Attacks on his socal integrity. The guilt feelings prevent the patient from reacting aggressively to the attacks of his enemies. The aggression, repressed by the guilt feelings, is converted into self-accusations and causes psychic depression.

In the course of the psychoanalysis, the patient's guilt feelings were lessened and his aggressiveness was able to gradually direct itself more towards the outside instead of against himself. There was a phase in the treatment when the above-mentioned aggression could even have been able to come face to face with the external world; but the guilt feelings were still strong enough to prevent this goal from being achieved. During that phase, the patient attacked society in general which he considered to be the cause of all his troubles. Ultimately, when the guilt feelings were already almost completely removed, the patient was able to attack his enemies directly and with this a triumph in his social life took place.

The self-reproaches of the patient in the depressed phase were therefore reproaches which wanted to but could not be directed against the external environment because of his guilt feelings. The more attacks his enemies leveled against him, the greater became the recriminations which he hurled at himself thus increasing the repressed aggression. And the patient's ideas of suicide, like the self-accusations, were really death wishes directed against his enemies which, secondarily, were turned against his own *ego*.[1]

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[1] In the famous monologue of *Hamlet* (third act, scene I) can be observed the very moment when, confronted with the impossibility of struggling against the external aggression, the *ego* turns its aggressive impulses against itself and thinks of suicide:

Endogenous melancholia has a psychology resembling that of psychogenic melancholia. It must be recognized that the affective relationships of the melancholic with the objects of the external world are always ambivalent, even in the non-depressive phases. This ambivalence frequently causes conflicts which accompany the loss of the libidinous object. This loss can be real or only intrapsychic. The mechanism of psychogenic depression is released by the loss of the libidinous object which could be caused either by real occurrences or just as well by constitutional motivations.

Note continued from previous page.

Hamlet.—To be or not to be: that is the question:
Whether 'tis nobler in the mind to suffer
The slings and arrows of outrageous fortune,
Or to take up arms against a sea of troubles,
And by opposing end them? To die: to sleep;
No more; And by a sleep to say we end
The heartache and the thousand natural shocks
That flesh is heir to, 'tis a consummation
Devoutly to be wish'd. To die, to sleep;

Hamlet debates the problem of whether he ought to seek a remedy to all of his troubles by means of self-death. He decides in the negative, thus submitting himself to divine law (first act, scene 2)

or that the Everlasting had not fix'd
His canon 'gainst self-slaughter!

The whole question is a debatable one and opinions differ concerning it. Among the philosophers, some defend the liberty to take one's own life, as Schopenhauer does (*On Suicide*):

> There is nothing in the world to which every man has a more unassailable title than to his own life and person.

Other philosophers, Kant among them (*lecture at Konigsberg*) criticize this view severely:

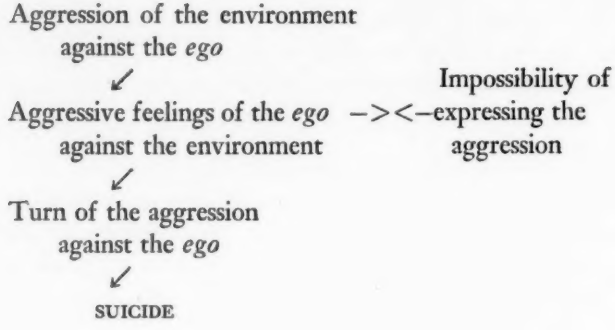
> Suicide is not abominable because God forbids it; God forbade it because it is abominable.

The problem of the liberty to commit suicide goes far beyond what our study attempts. Its psychoanalysis must be carried out jointly with the study of the religious and moral idea of the individual and society.

With further reference to Hamlet's monologue, and whether he should or should not kill himself, fear has often been suggested as a factor leading to self-destruction. Marcial already called attention to this in one of his celebrated epigrams, when he asserted that, when the joys of life no longer exist, the coward drags himself towards death while the brave man continues living.

However, the lover who kills himself after he loses his greatly beloved woman, the faithful vassal who commits suicide to share the fate of his deceased chief, or the soldier who offers himself to save his country, all cannot be viewed as timorous people. Nor can many other individuals, among them some great men, who took their own lives as a result of actual war, in inspired moments when the cruel prolegomenas of the unchaining of the conflict or the capture of Paris by the Germans took place, be char-

In summary, taking into consideration these additional psychological data, the origin of suicidal ideas can be represented by the following diagram:



The Aggressiveness in Suicide

We will now attempt to prove, through various practical cases, the truth of the psychological process just described. That is to say, we will inquire whether suicide is an aggression against the external environment which secondarily and for a number of reasons, has been turned against the *ego*. To accomplish this, we will refer to the psychological study of cases of real suicidal attempts, then of cases and attempts at suicide described in the literature and, lastly, of data furnished by statistics.

A patient of ours had the following fantasy: he imagined that a war had been declared and that he was obliged to go to the front as a soldier. He recalled a scene he had read in a book (Barbusse, Le Feu), in which

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Note continued from previous page.

acterized simply as cowards. These and other examples show that the psychology of suicide is too complex to be able to be explained on such a simple basis as fear.

On the other hand it must not be forgotten that frequently fear averts suicide. Dorothy Parker, in *Resumé*, ridicules suicide in the following verses:

Razors pain you;
Rivers are damp;
Acids stain you;
And drugs cause cramp.
Guns aren't lawful;
Nooses give;
Gas smells awful;
You might as well live.

some soldiers are ordered to attack an enemy trench. They have to pass by a place where bullets and hand grenades kill many of them. At this point in his fantasy, the patient is terrified and decides that, in the event of war and general mobilization, he would commit suicide before going to the trenches. The same analysis, previously described, holds in this suicidal fantasy: the trenches represent the aggressive environment; the inevitable obligation of going to them as a soldier symbolizes the impossibility of overcoming the aggression; finally, the suicide is the turn of the aggression which could not be opposed, against the subject's own *ego*.

Another patient, one day, related a fantasy as follows: "I am capable—he tells us—of carrying the woman I love to the bed of the man who covets her and then committing suicide." The man who takes possession of the woman whom the patient loves, is strongly hated by the subject; the neurosis of the patient prevents him from satisfying his intense hate; and finally this hatred which the patient could not express, turns itself against the *ego*, resulting in the suicidal fantasy.

Fantasies, resembling the one just described, occur quite often particularly in attenuated form. For example, the bride of a patient once remarked that even though she was married to him, if she fell in love with another man, she would leave him. This conversation was the source of one of the patient's fantasies in which what she had prophesied actually happened. The patient continued fantasying that, if that occurred, he would continue to be on good terms with his wife, would support her and have children with her, so that she could be completely happy. Then he would commit suicide inasmuch as life would have no further purpose for him. The psychology underlying this fantasy is the same as that entering into the previous patient's fantasy.

A schizophrenic man, who committed suicide, a few days before his death had fantasies of the following type: the idea occurred to him of killing the nurse who watched over him. He then imagined that he would shortly thereafter be incarcerated in a prison. But, since it would be demonstrated that he was insane, he would be placed in a State sanitarium, where, according to the fantasy, his family would only be able to visit him once a month and he would lead a miserable existence. In this fantasy the aggression is observed in the idea of killing the nurse. These aggressive ideas are impossible to realize because of the subject's fear of prison incarceration and placement in an insane asylum. This

desire of aggression directed to the outside, impossible of being expressed, caused his suicide.

King Charles VIII of France was physically very ugly and, in addition, had a bad case of halitosis. When he entered Naples, he sent for a group of youthful fish-women from Santa Lucia and, selecting the most elegant among them, a worthy girl of sixteen years, he spent the whole night in her company, partaking of the delights of the flesh. On the following day, the girl, disgusted by the horrible night, climbed to the top of a rock and committed suicide by hurling herself into the sea.[1] The suicide of this girl stems from her desires to kill the king. Since those desires were impossible of fulfillment, they were turned against the girl herself. Her suicide psychologically signifies the wish to kill the king.

Aggressiveness against the external object is what leads to suicidal ideas. If the aggressiveness towards the external world changes in aspect for any reason, the ideas of suicide become modified. Thus, a patient, at the beginning of her psychoanalysis, had ideas of suicide. In the course of the treatment, we caused her aggressiveness toward the outside, which was especially evident in her relationship with her husband, to diminish. This modification brought as a consequence the fact that the patient no longer had such a strong desire to commit suicide. Nevertheless, her infantile conflicts which were not yet completely resolved, still drove her to desire death. In this phase of the treatment, the subject sought death through illness; she tried, for example, not to protect herself from the cold hoping to contract a pneumonia which would kill her. She reasoned that, in such an event, her husband would not suffer as much as if she died by way of suicide.

When the external environment ceases to be disagreeable, the aggression disappears and as a result the suicidal tendencies also peter out. This occurs, for example, in the following case of Ferri's referring to the suicide of a couple[2]: "Amadeo drew out the revolver which he had purchased the previous day. Rosina remained absorbed in contemplation of the approaching end; after a while as if revived by a sudden desire for enjoyment before dying, she says: "Let us make love (in other words let us caress each other) before killing ourselves.' Afterwards, Rosina incites Amadeo who was beginning to vacillate, to kill

(1) Cited in Klanbund: The Borgias, Cénit. Madrid, 1930, pp 127 and 128.
(2) Ferri: *Homicide-Suicide,* translated by C. Pena, Rens, Madrid, 1934, pp. 131.

her; he does kill her; but then does not have the courage to kill himself. *Perhaps the pleasure he had just enjoyed had re-awakened in him, the love of life*".[1]

The same occurs in the suicide stated by Paul Bourget in his novel, *The Disciple*[2]. Two lovers wish to commit suicide. But before dying, they decide to engage in coitus for the first time. This satisfies the man fully but the woman experiences nothing. As a result of the pleasure he experiences, life, for the man, is converted into something agreeable and aggressive tendencies no longer agitate him. He therefore decides not to commit sucide. But the woman, who had remained frigid, still possesses the same psychological conflicts as before and consummates the suicide.[3]

We will continue examining more cases of suicide, which have been described in the literature, in order to demonstrate whether they obey the same psychological laws as those which we have described up to now.

Alfredo de Vigny, in *Chatterton*, describes the suicidal motivation of the leading character in the following way[4].

> He is attacked by a moral sickness, almost completely incurable and often contagious; a terrible illness which most often takes possession of youthful souls, ardent and new in life, which afflicts the beautiful and the just, and which visits the world *in order to encounter, at each pass, all the uglinesses and iniquities of a badly constructed society. This evil is the hate of life*[5] *and the love of death: it is the obstinate suicide.*

This psychological situaton also appears in the famous monologue of *Hamlet* (third act, scene I):

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(1) Author's italics.

(2) See our work: Die Realität und das Es in der Schizophrenie. *Internationaler Zeitschr f Psychoanal.*, Volume XVIII, p. 189, 1932, or its Spanish translation: La Realidad y el en la esquizofrenia (Reality and the Id in Schizophrenia). *Archivos de Neurobiologia*, p. 604, 1931.

(3) Freud repeatedly shows that the erotic instincts neutralize the aggressive tendencies which proceed from the death instinct. The examples previously cited refer to direct heterosexual situations, but the same phenomenon is also presented with homosexuality and with instinctive sublimations. This is demonstrated in the following letter from Beethoven to Franz Wegeler:

> "I would have committed suicide long ago had I not read somewhere that it is *a sin to part from life voluntarily so long as one can still do a good deed. Life is so beautiful, but for me it is forever poisoned.*"

(4) Second act, scene V.

(5) Author's italics.

For who would hear the whips and scorns of time,
The oppressor's wrong, the proud man's contumely,
The pang's of despised love, the law's delay,
The insolence of office and the spurns
That patient merit of the unworthy takes,
When he himself might his quietus make
With a bare bodkin?

The existence of aggression from the environment which cause the ego to think of suicide can also be observed in this monologue. The extent of the aggressions is clearly illustrated at the end of the tragedy when Hamlet kills Polonius and then King Claudius and Laertes. (In the monologue cited above there is an emasculation of the aggressive situation of the external environment. This is evidenced by the fact that Hamlet does not complain about his malicious uncle but rather about something vague and general about part of which he hardly has cause to complain considering his privileged position of crown prince.)

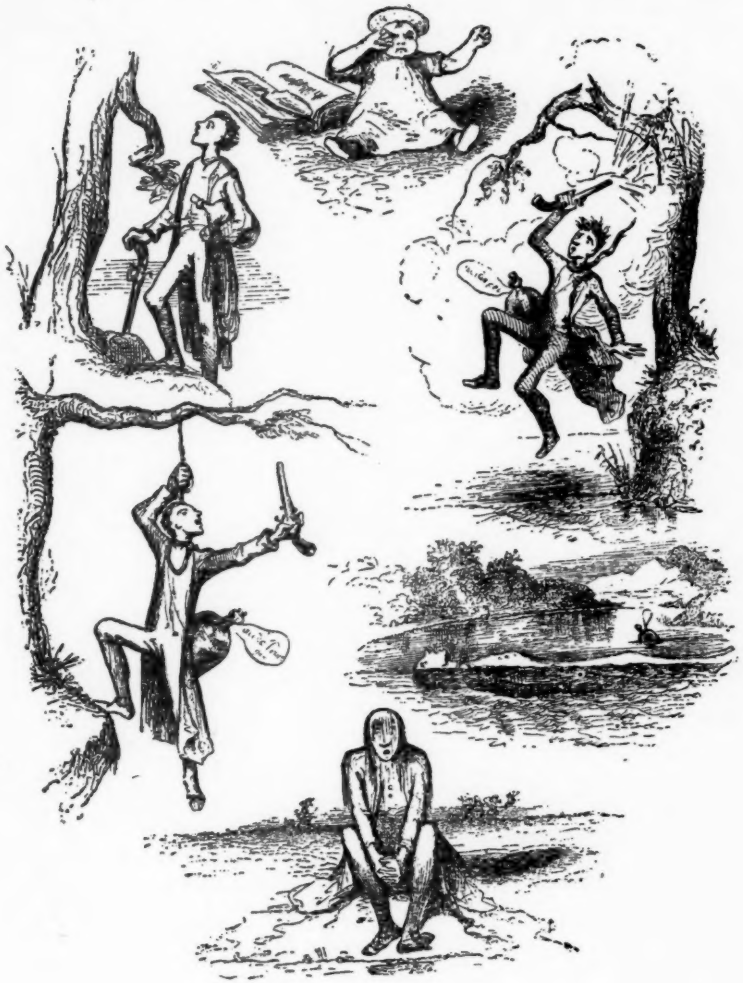
The examples could be multiplied. But we will limit ourselves to citing only one more, perhaps the classic instance in all literature. Let us refer to *Werther.*

When this work is examined superficially, there do not appear to be any aggressive feelings in it. As a matter of fact, Werther continually speaks of his beloved Carlotta and of her husband Albert, as if he considered them endowed with all the finest traits and as if he was extremely fond of them both. But, when the work is read wth deliberation, certain details are found which confirm the existence of strongly repressed aggression.

Thus, Werther says: "When I am asleep, I cannot free myself from the following thought: *What would happen if Albert died?*[1] In other words, desires for the death of Albert obsessed him during sleep. His aggressive feelings also were manifested in another obsessive idea: that of imagining that he had destroyed the beautiful cordiality between Albert and his wife. He reproaches himself for this and also evidences a *feeling of antipathy aganst the husband.*"[2]

Carlotta is not the angelical soul that she superficially appears to be. Not only did she contribute to Werther's suicide but prior to that she had caused the insanity of another man, who "was a clerk in her father's store, and was in love with her . . . for this reason he lost his job; which

(1) Goethe: Gesammelte Werke, Volume VI, p. 66, Voegel. Berlin, 1927.
(2) Op. cit. p. 83.



ATTEMPT AT SUICIDE

T. Johannot, A. de Musset and P. J. Stahl: *Voyage ou il vous plaira.*

I took a rope, a pistol and a good dose of poison one after the other. Besides I threw myself into the river. . .

The bullet . . . had cut down the rope.

. . . The water made me vomit up the poison.

. . . I then told myself that I had already done enough for love and decided never again to think about the beautiful half of human kind, to whom Plato and a learned council denied the possession of a soul.

in turn drove him to raving madness."[1] He spent an entire year in an insane asylum in chains.

There are other small details in the work which enable us to surmise the aggressive feelings of the personages. Thus, the pistols with which Werther commits suicide belong to Albert and Carlotta herself presented them to him.[2] Another example of an aggressive detail is the description of a crime: the servant of a widow who was dismissed from her service because he fell in love with her, kills the new servant.[2]

It is not necessary for us to describe the guilt feelings of Werther as a result of his guilty love; it is clearly apparent in the psychic make-up of that character. Those guilt feelings cause the aggression to turn from the external object against the *ego*, thus impelling him to seek his own death.

A literary production *sui generis* is the joke or jest. Freud has already called attention to its great psychological value inasmuch as, by various techniques it brings unconscious processes into the realm of the conscious. In view of that, jokes concerning suicide can be used to confirm our previous observations. We will here cite only two examples. The first consists of a dialogue:

——Four of my childhood friends have committed suicide.
One of them—poor Henry—because his wife died on him.
——And the other three?
——Precisely for the opposite reason.

The mechanism of this joke is as follows: The three friends were married to such intolerable women that they developed desires to kill them. Since the realization of such desires for their death was impossible, they had to turn the aggression against themselves by committing suicide. This technique, expressed in the joke by means of ellpitical distortion[3] and by contrasting the conduct of the three friends with that of the first friend, makes us laugh thereby disclosing profound psychological processes to us.

Something similar occurs in the following cartoon. The accumulated aggression against the external object which is at first repressed and thus turned against the *ego* is, in the last picture, rapidly and violently

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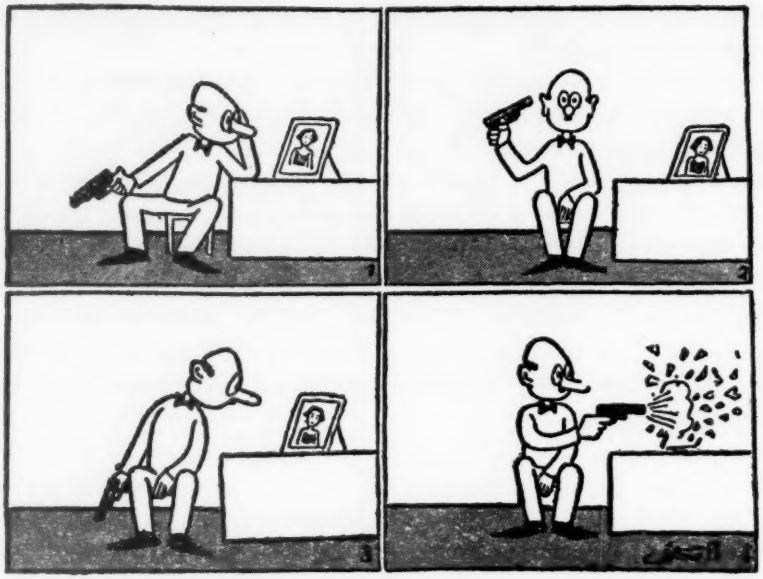
(1) Goethe: Gesammelte Werke, Volume VI, p. 78 and 80, Voegel. Berlin, 1927.

(2) Op. cit. pp. 84, 105, 107.

(3) As Th. Reik also demonstrates this (*From Thirty Years with Freud, The LaLtent Meaning of Elliptical Distortion.* Farrar and Rinehart, New York, 1940, pp. 212. The cllipsis has the significance of death wishes against some person.



directed against the picture of the object that caused it. This abrupt liberation of the repressed aggression provokes laughter.(1)

Continuing further with the present study, it can be demonstrated that, just as in real cases of suicide already discussed and in those described from literature, statistics bear out the close relationship between suicide and aggression which the external world arouses. We will cite some data.

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(1) Many jests have been made concerning suicide and suicidal individuals. (See Meiers and Knapp: *Thesaurus of Humor*, Crown Publishers, New York, 1940, pp. 34-35) but those which show the principal psychological mechanism involved, as clearly as the ones already cited are rare. Some that are analagous to the ones cited are the following:

> I'm going to shoot the man who married my wife.
> But that's murder, isn't it?
> No, it's suicide.

> Statistics prove that marriage is a preventive of suicide.
> Yes, and statistics also prove that suicide is a preventive of marriage.

Other jokes about suicides, although they are concerned with whether the act is completed or not and with the underlying reasons for it, primarily serve to consciously reject the idea of suicide and thus relieve psychic anxiety. They usually do not have recourse to logical thought processes. But, when they are told or heard, they promptly result in a removal of the necessity for disagreeable psychological tension. This release of tension occurs by identification with the suicide or persons related to him. An abrupt discharge of tension takes place and the repressed aggression is released in the form of laughter.

Statistics prove that when there are emotional attachments which bind the individual to a familiar social environment, the number of suicides is less. Thus, married people, particularly men, commit suicide less often than soldiers; having children also protects against suicide, and the greater the number of children, the greater the protection. For similar reasons, suicides diminish in number during periods of war or revolution, owing to the presence of a collective ideal which causes the individual to better defend himself from the aggressions proceeding from the external world. And conversely, suicides increase in periods of the defeat or overthrow of a country or of a social or political order.

The question of whether there is actually an inverse relationship between homicide and suicide, as has often been claimed, would also,

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That is what happens in the following stories concerning possible suicides, where the play on words makes light of the gravity of the cases:

But why don't you get a rope and string yourself up on a tree in front of her house and that will make her feel terrible.

I would, but I can't do that.

Why?

Because if I were dead, she wouldn't want me hanging around.

Do you love me?

No—mine is an undying love.

Would you die for me?

Yes, dear.

The deflection of the hearer's attention toward something of secondary importance also calms him down.

My father committed suicide.

That wasn't very thoughtful of him.

I'll say it wasn't—when he got through he didn't turn off the gas and our bill was terrible.

(Man sentenced to 90 years kills himself in court)

Judge: That will be ten years more for contempt of court.

In real life the transcendency of the cases of suicide is too often minimized by making them appear as having been caused by some mental illness. Some jokes do the same such as the two below in which the suicides appear as individuals deprived of their sanity.

How do you know that the man who shot himself was insane?

He had two teeth filled an hour before he did it.

Why did your uncle commit suicide?

On account of his absentmindedness.

What do you mean?

He went to a citizen's training camp and shot himself one night when on guard duty. He forgot the password.

The laughter, in the first case, is provoked by the discovery of the mental illness through a small detail to which little importance is usually attached and which is only a minor item in the symptomatology of the psychosis. The second case is based on the psychological truth of various lapses in the individual's psychic apparatus.

if it were proven, be a confirmation of the previous data especially since suicide is aggression against the *ego* and homicide is aggression against an outside object. Durkheim, Ferri, Morselli, Bournet and Corre all affirm that homicide and suicide are inversely related while Tarde, Feré Silió and Halbwachs deny such a relationship.(1) In view of this disparity of opinions, a categorical position on this question cannot be adopted. Nevertheless, the fact that a hypothesis of this kind was formulated indicates that, psychologically, the existing connection between aggression toward the exterior and aggression against the self, is somehow felt.

Halbwachs sums up some statistical conclusions in the following terms: "The number of suicides is a fairly exact indication of the amount of suffering, uncomfortableness, disequilibrium, and sorrow, whch exists or is produced in a given group . . . Social conditions are the only ones which cause the number of suicides to vary," inasmuch as individual conditions varied only slightly in the course of several centuries.

"Common sense" fails to recognize that "the individual form in which these acts (suicides) occur, is only an appearance and that their number and distribution are a consequence of the structure and way of life of society."(2)

In other words statistcal data also support the thesis that aggression against the external world secondarily turns against the *ego* causing suicide.

(To be continued)

Note continued from previous page.

Attempts are made to prevent suicides by studying them from the point of view of the psychology of the individual and drawing practical conclusions. The joke also makes effective use of this technique but with special procedures:

> Oh, sir, there's a Scotchman out here who wants to buy ten cents worth of poison to commit suicide. How can I save him?
> Tell him it'll cost twenty cents.

In the above joke the laughter results from the ease with which it was possible to avert something as terrible as suicide. The psychic relief obtained becomes even more intense, if characteristics which the embittered individual firmly maintained in life are discovered in him. That is to say, if there is an energetic selfishness for continuing to live in spite of everything. The clearly expressed psychological act of suicide would ordinarily be disagreeable to the hearer but indirectly it can be expressed through jokes with happiness to the hearer!

> You picked a good day to end it all by drowning.
> Something is holding me back.
> What?
> I can't swim.

(1) E. Ferri: Homicide-Suicide, p. 303.
(2) M. Halbwachs: Les causes du suicide. Alcan. Paris, pp. 488, 511, and 514, 1930.

THE SIGNIFICANCE OF AMBIVALENCY FOR SCHIZOPHRENIC DISSOCIATION

A Clinical Study

DR. P. LIONEL GOITEIN
Woodbourne, New York

(*Argument*: The developmental causes of precox may link the dissociation, met with in the disease, to the pathologic split occurring between component forces of instinct, positive and negative. Attempted harmony results in an impossible compromise, and certain schizoid aspects of thought reflect this. A neutral language and behavior is invoked (of primordial expression) to shield the ego from narcissistic shock. Each case has an anachronistic quality deriving from an attempt at *identification with the past*, thereby forcing the present into a retroactive frame of reference. An illustrated case (rich in phantasy material of such order) develops this new aspect of the problem of Dissociation, as one of the resultants of instinctual block, on oral sadistic and urethral sadistic planes; the neologism and grotesqueness being in part *restitution* phenomena for suppressed content.)

INTRODUCTION

It is commonly recognised that the equivocal and often bizarre picture presented by the disease Schizophrenia is evidence of extensive intrapsychic dissociation. A fresh attempt is here made to elucidate the ultimate sources of such dissociation. We know that separate streams of consciousness which betray the precox mind exist without apparent discord in a special mental system, harmonised with the self by virtue of an irremedial instinctual dissociation, that springs from the most profound levels of development. The exact lines of cleavage have yet to be determined.

Whereas the splitting is usually in evidence clinically in the divorcing of affect from reason (e.g., the senseless laughter), of sensation from action (the placid inertia), of thought from intuition (compelling hallucinations) or of feeling from expression (immobile facies), etc., and finally in the readily displaced *unstable equilibrium* existing between all these, there is still a deeper dissociation that, in the last analysis, may be responsible for them all. It is our thesis that the deeper conflict in this disease concerns mind's instinctual dichotomy, and lies in the duality of aspect of instinctual function (hostile and amicable). At some time a split occurs in an impossible compromise between antagonistic components. We refer to specific twin systems such as submission and aggression, withdrawal and assertion, introversion and extraversion, separation and dependancy, curiosity and denial, that exist as

drives of significant strength, but with the socially less desirable usually maintaining the upper hand. This dilemma manifests whenever great instinctual forces are stirred, at the same time.

This thesis sets out to examine the structuralisation of the precox life and the forces that transform it, confirming it in one long anachronism. Now the peculiar anachronistic quality of all schizoid thought appears to derive from a wholesale transvaluation of personal *id* values, in the course of the disease. Herein, it is believed, lies an attempt at retrospective aggrandisement of instinctual *press*, at the expense of ego forces, whilst the factors of a profound introversion serve to enhance the oral and urethral features of the mental regression involved.

THE INSTINCTUAL DICHOTOMY

In dementia precox the dual components of Instinct split, and function at the expense of each other. Each will manifest only when the other aspect is repressed. The split also involves a dissociation of other psychic elements (e.g. affect from conation, impulse from thought, etc.), which represents the logical outcome of the primary dichotomy. Thus, (1) Aggression-Submission in phantasy, (2) Construction-Destruction, (3) Separation-Cohesion, etc., seem to function in pairs.* This mode appears as consistent for the phantasy life, as it does under 'conditioning' experiments in laboratory or reality situations.

Probably the singling out of a single quality (say Aggression with dullards) for study, gives unwarranted importance to one small facet of the instinctual life. It has long been recognised in analytic procedure that with libido frustration, anxiety or aggression is the expected outcome; which may then seek fresh canalisation in the current situation. Frustration leads to a mechanical block when the thwarting condition is complete, coincident with heightened tension. A character trend of Submission, as the opposite pole to Aggression, finds outlet only when repression occurs. In precox a compromise formation has been secured.

This individual we are about to discuss was chiefly remarkable for the powerfully repressed positive aggressive currents at work in his Unconscious, clearly finding substitutive gratification in delusional phantasy. This takes the form of hold-ups, murder, manhandling, warfare, or *symptomatically* in isolated psychopathic behaviour in one instance of assaultive *crime*. The character of the instinctual urge, we found,

(*) *vide infra* "The Major Themes of Ambivalent Phantasy."

largely urethral sadistic in tone. It is typical of the schizoid mentality that pregenital urethral aggression is turned back on self in destructive enterprise to form the basis of the disease. Only by further regression is oral sadism involved. The explanation is as follows.

The sadistic quality of these instinctual components, with all their dangerous aggressive and acquisitive violences, tends to drive the ego back, which protects itself as best it may, with a cloak of inviolacy and deep introversion. In such connection we draw attention to the complex mechanisms in evidence: the disease of language and ideational conceptions inherent in precox word-play and "word-salad"; the curious neologisms and megaloid beliefs, the lingual conversions and sense of magic, also the feeling of unwonted power, marking the transformation and regression of libido back to oral (speech) levels, or to events on the prelingual phase of development. In such instances we find frequent reference (in phantasy) to defence from attack by verbal protest; securing of some sequestered object by shouting loud; silence and isolation from objects, all of which signify for the child the discovery of some powerful *reality* weapon, which speech and gesture, also bodily expression and histrionic demonstration, contrive to realise. These are utilized later in aggressive violences in the service of the oral phase, a potency only won at the price of constant frustration and loss of esteem.

Part Whole Identifications

Now the oral levels of regression function throughout schizophrenia in the constant linguistic expressions of atavism. The curiously consistent reference to primordial symbolism of the *serpent* order in these cases, makes it clear that we are dealing not with snake as fertility symbol (i.e., the constructive or destructive phallus), but largely as oral gratification object in hallucinated phantasy, i.e. the nipple, transferred to self only as its late equivalent for ipsation. The fear of aggression covers the unconscious desire for aggression by means of the all powerful penis, (the nipple now incorporated); and our patient's schizophrene phantasy bears constant witness to the magic potency of this wish organ. The part-whole identification finds frequent illustration, and it may well be typical of primitive thought of the kind met in precox, that there is inability to identify completely with any object, while projective capacity is maintained. This is seen in the cosmic extrajection of the breast* in the form of moon and stars. Such is the price of the deeper introversion.

(*) *vide infra* "Cosmic Representation of Conflict."

The all-Mother becomes the cosmos and the unity of Nature. The patient in reaching back to the sun, moon and little stars, touches on emblems of the poetic Unconscious, rarely tapped in analysis. Our subject, it will be shown, formulates maternal and prenatal constructions, in which the prime mother-self involvement and unity is preserved, for the steps of separation, frustration and isolation, etc., are only achieved by gradual evolution, evolution of libidinous currents of the ego at the expense of the id.

CLINICAL ASPECTS

The subject we are considering unites his world system into the most primitive elements of his disordered mind. It will be seen how his phantastic world was populated with creatures of his own making, since his "god had died millions of years ago." He retired from a world where "the callous faith of men ruled and civilised life was losing ground." He also had "devil thoughts" and sought to rectify them by composing exotic poems on the life of the Bee! He thus already showed all the symptoms of a profound introversion when first seen.

Incidentally, he describes the psychopathic episode of his crime (Assault) with a calculated indifference, as he "comes to earth;" e. g. his cold vicious intent to "stick up somebody," for "I've got everything you've got!" From this phase on he was preoccupied with firearms and explosives, boxes of bullets, rifles, targets and pistol shots . . . "I'll hold up a gun store and take the lot." This discovery of such fascinating source of power proved too much for him. Evidently at one period in adolescence, the strength of his newly discovered manhood was overwhelming, and his genital impulses psychically dominated him. He wanted next to be a chemist or to study disease, even to be a geologist in search of gold! He reviled his overseers in any jobs he held or ever could get. For with every boss he sought revenge for cruelty suffered at home. "I was determined to be a big shot, but I didn't know how!"

There was devaluation of all rivals and an aggrandisement of self, and of egotistic virtues in keeping with his megaloid ideas and incubating systems.*

FACTUAL MATERIAL

This is the life history of an only son, born of German parentage. Early in life, through the father's ungovernable temper, a cleavage in

(*) *vide infra* "Psychotic Depreciation and Aggrandisement."

the domestic set-up had occurred. He was 3 years old. The father, throughout his life, was a skilled mason in marble, "earning good wages," and able to support his family up to 2 years after his divorce Thereafter the boy lived with his mother or grandmother, (to whom he was deeply attached, and with whom he slept). They lived in "marginal circumstances," and had on occasion lived on "relief" for 6 years before this crime. Our patient disliked teachers. He reached sixth grade at school and was labeled early "a chronic truant." Psychologically, at 12 he was first considered a "moron of medium grade 5½ years retarded," but "physically overmature." At 17 he was arrested on a breaking-in charge, he having been the "look out," when other boys broke into a Gospel Hall and stole $8 from an unlocked box. For this he was sent to Opportunity class, and here he learned the Metal trade.

He ran away the following year from a State school, being duly considered "sullen and resentful," in that he "refused to mix with older boys" but enjoyed his one Boy's Club activity. Other observers felt he was " an unstable Personality" at this time, with "a schizoid constitution, antagonistic to authority" and with "no insight."

As a first job he was given a Janitor's post at a theatre, soon after becoming involved in one or two escapes from his institution. At another Industrial school he worked in the Laundry. "No progress" was reported in Education, also he had "reading and writing disability"; that further he was "unstable, always alone, never trusting anyone." He "struggles with superiors" and "likes to tramp" . . .Also he is "deeply antagonistic to the opposite sex. We suspect retarded sex development"; and although he "bites his finger nails" is "not quick tempered or nervous". He is "interested only in his own affairs." Finally he is diagnosed "paranoid with inferiority complex; of hopeless prognosis."

Next he was involved in stealing men's and women's underwear from a shop window. Later he started to "use aggressve talk," liked to "see blood of his own wounds" and bragged he was "used to be cut up" and "called the mother vicious names."

He lost, by death, the father and grandmother 2 years after the first crime, which affected him overtly only as "crying in sleep." The mother is since reported "emotionally unstable." He was reported about this time as "suffering from dizzy spells," but no fits were noted. Perhaps the loss of two emotional objects of different value at such time, set free aggressive components he could not deal with.

TRAUMATIC EPISODES

In the course of investigation he has appeared more cooperative. Some insight has returned, and with it many repressed memories of childhood, which in part explain his subsequent reaction plan. For example, he recalls

The life with the grandmother after the parents had separated; every detail recalled suggests a close fondness and attachment to her. She is the only rallying figure in a hostile world; she frequently recurs as savior figure in his dreams.

Infantile traumatic situations and experiences are described (e.g. deprivations and hardships; life with the shell-shocked father and later advances of a degenerate "lodger"; punishments and blandishments from the mother); the rigorous upbringing; shouting in sleep; enuresis and "weak bladder" up to 6 years; at 17 fear of self-injury by ipsation.

The love of adventure and exploration. Early determination to flee from home. He was prepared to wander; restlessness, shunning of society, and curiosity toward the unknown.

The Inventiveness; a certain grotesqueness seems to have colored this impulse from the start. He always wanted to "improve the universe," and created imaginary inventions for "perpetual motions," etc.

The Isolation and sense of distance has been present from earliest years, e.g. in the poor home, bad conditions of living, the need for solitude, the opportunity for revery, non-understanding by his elders, all this produced an individualistic bizarre type. "I was born mad."

The learning process came difficult owing to his antipathy towards teachers; he was "disinterested and absorbed"; he never found common ground with his school-mates. The need for emotional understanding by his teachers was strong.

The Oedipus Situation was never worked through. It came furtively to the fore in dream work only after 9 months of analysis. The phantasy life now gives unmistakable signs of living out this phase in the transference situation (a crisis in his institution life has occurred also).

The Lilliputian Hallucinations e.g. "a man looks like a child in front of my eye until he gets smaller and smaller"; there was also one of a frightening hawk (memory ?).

The Fully Developed Psychosis (as reported) was readily manifest now in the early stages.

The Sexual Life and Current Behavior

The libido life has remained largely inhibited. In regard to his sex affairs, he was "afraid of contacts," had panic at first kissing someone, but at the age of 18 he became involved with a "young girl of a good family." He made a fair advance, but there were "complications with the father." He felt it was all arranged as a trap; but they treated him, he says, as if he had raped the girl, and "kept razzing me about it" . . . "I felt it deeply, I burnt up inside . . . I was jealous of all women . . . I was defeated and my mind was licked too" . . .

While in the institution, he has steadfastly refused to write to his mother who is sickly now and has a cataract. He adopts a blaming attitude towards her also, and there is a strange lack of affect in his demonstration and description. He has no expressed loyalties to anyone. Here he has rarely been observed to smile.

There was noted more recently by one of his overseers his "despairing moods and periods of hilarity and affability," his staring into vacancy and "contorted features as though distressed"; also his assaultive impulses and "mutterings, usually derogatory of others." He has now the offer of a job and an approved programme of parole, but is still listless and irresolute, and is content with institutionalisation.

Psychotic Depreciation and Aggrandisement

In keeping with the psychotic elements in his nature, he boldly demonstrates his megaloid phantasies and depreciates others' psychic values. The withering scorn and fault-finding of people often displayed by the schizoid, must be understood as related to the heightened ego values narcistically entertained. Our patient dreams:

. . . "An array of 25 large cats range along the stage of a theatre. I see an enlarged fence because the cats are larger than usual. There are orange and white animals. None is dark. I am chasing one of them as it is mounting the fence. . ."

Note the animalistic parental inversion and dehumanization here manifest. His artistic productions also showed (as do schizophrenes in general) similar compulsive conversion traits. Again:

". . . I am wearing a mask. I hold up a woman for some better clothes. I knock at a door. 'Who's there?' 'I am sorry (says a woman's voice) I don't know; I can't tell. Try next door!' I get a pair of pants and suit given me, and I discard my soiled shirt . . . Next I go up the splendid stairway of a big Hotel without being observed. . . "

(Later) ". . . a large mansion with a flight of stairs like a snaky curve. I look up, it seems familiar; it's very big below and it goes high."

Here the infantile recapitulation of the hold up of the mother, the deflective defloration, the sexual ascent and particularly *the origin of all crime,* is sympathetically portrayed. It nicely illustrates the retrospective aggrandisement of the original maternal object, and the deflection of *guilt* from self, the unworthy worshipper (soiled).

INFANTILE SYMBOLS

The anachronistic mind of the Schizophrene is chiefly remarkable for its ready change of idiom, its reliving the present at the expense of the past or future, and its translating the performances of everyday life into the language of another world (the Unconscious), such that its entire speech mode needs translation. Such linguistic identifications make for a constant source of delight to the self, something of prized originality. In process of living now he belongs to an atavistic past, which bears all the signs and symbols of the primordial tongue. It is "as if" they had umbrellas in paradise! He hallucinates

(a) of "the milk snake with light brown breasts and with a mouth shaped like a crane" though this emerges also in his dreams. Another example:

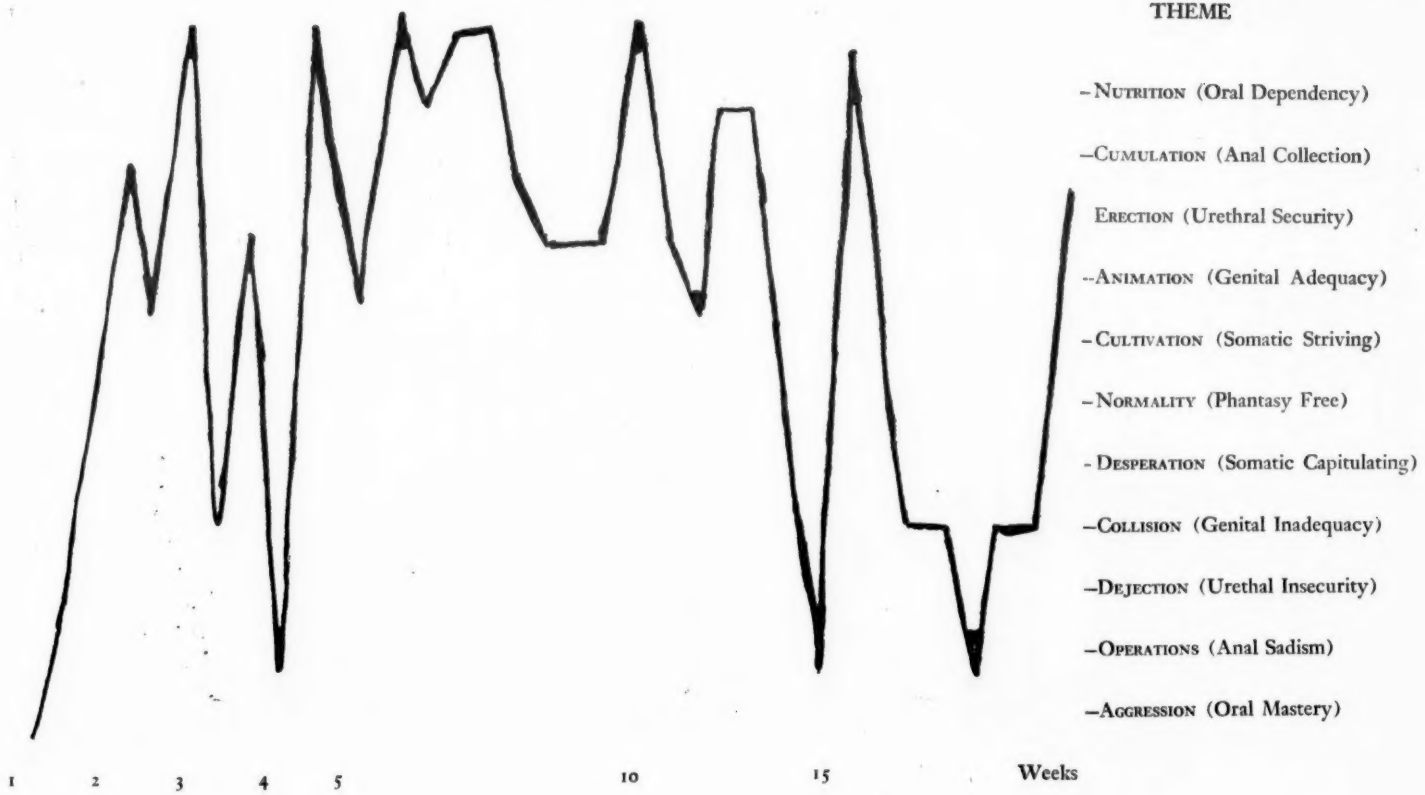
(b) "a snake is crawling alongside me; I lie down to test it out. It has got furs all over it like suckers, colored brown and blackish. Every turn I make it comes after me, it licks my hand; its tongue is almost human." Again we noted in his dreams

(c) "a pipe . . . it wobbled like a snake, it had a valve-like white speck in the center; it gets stuck, then it explodes and bursts into fireworks."

(d) He describes a "flight of stairs like a snaky curve" situated in a large mansion. It is "big below and goes high up."

(e) Primitive symbols allied to the foregoing arise in conversation. Thus decided references to atavistic symbolism of this order, indicate

Fig. 1 Psychoanalytogram in Oral Masochism



the strong phallic preoccupation. From the above, the repressed homosexuality can also be deduced, and the equating of *eruption-nipple-phallus* here is noteworthy; the conflict is with the introjected super-ego.

The Robber Game

Few criminal psychopaths fail to identify at some time in their childhood with the Robbing Game, comparable to the "Doctor game" in the destiny of the future physician. This frequently comes into our patient's psychic life. He dreamt:

". . . I was playing cops and robbers with some cop I was the thief. I'm jumping over roofs and houses. I fight them all and get away. I organise a small gang, but there are gun emplacements everywhere, so I had to hide away . . ."

It is considered that the underlying genital conflicts (that favor psychopathic outlet, rather than Character change or neurosis) in most of these instances of resistance to law and order, are unresolved.

Emergent Phantasy Sequence

We propose now to summarise briefly the phantasy content of the first years of analysis, reducing to simplest interpretation the dynamic intrapsychic tendencies therein expressed. It was found that the Themata arranged themselves into certain well-constructed plots of repeat content, that lend themselves to diagrammatic representation (see Fig. I) and to themal reference* with respect to the inner drama involved. The mechanisms implied, while not peculiar to precox, seem to be well exemplifed in this instance. We draw attention to the dichotomy so typical of the schizoid split, expressive alike of the ambivalency, the dissociation and the disharmony that characterises the anachronistic mind.

The main themes of his phantasy sequence were ambivalent, and fell to certain well-marked categories of content, that seemed to correspond roughly to oral, anal and urethral literal content. This formed a useful scale of reference for determining *levels* touched on in the analysis, as it was not felt that these represented levels regressed to permanently in the disease. We used its linear scale as one co-ordinate (Fig. I). The other abscissa marked the chronological order in weeks. For convenience we place Negative components below the normality line and positives above.

(*) *vide infra* "The Major Themes of Ambivalent Phantasy."

Some typical dream instances follow.

THE MAJOR THEMES OF AMBIVALENT PHANTASY

A—POSITIVE ASPECTS

A. *Aggression*—(oral power)—". . . A rain-storm comes up in summer. I must close all windows and pull shades down, for fear the wind will burst through the glass. Suddenly something goes wrong; the dam broke; water rushes in from the river till it comes up the steps. The wind broke loose."

Here the omnipotent bodily forces require restraint, lest they belch and squelch and overflow the whole world.

B—NEGATIVE ASPECTS

Submission—(oral frustration)—". . . I don't know which train to catch; there's a partition *wall* between each track. I hear one starting up, but I'm not allowed to go. I felt it was going; it started up at full speed, but went back on its tracks. I take enough *food* to last the day, but am warned against getting on the train, and have to walk the 900 miles. . ."

This is the acme of conflict; here the deprivation and self-denial operate when the inner oral urgency is strongest. The fiat of superego is accepted passively by an overpowered ego, now submissive, and responding only with substitutive gratifications.

B. *Cumulation*—anal acquisition)—". . . I come home with some wood furniture; it is so much that it got piled up and the truck capsized! I transfer it to a car. I explain to mother, who protests, that it's only thrown out lumber (mattresses and boxes) that we can't use. . ."

We deduce, the accident follows the overloading (of the stomach), but the retention of the *good object* is secured still.

Decimation—(anal castration)—". . . I see a crowd of mosquitoes, all brown and all of same size and formation, floating in air. 'I'll annihilate them!' They keep coming up, and I spray them. 'Where do they all vanish to,' I ask myself. Two cockroaches still remain on the wall. 'I'll get rid of these too,' I say, as I go to the next room for my shot gun and so to sleep. . ."

Note the repetition compulsion of the anal formation and its destructive urgency, as here when the two (parents), objects of his wrath, sleep in the next room.

C. *Cohesion*—(urethral inviolacy)—". . . Tornado is threatening us in my mother's house; a storm arises. 'You never know how serious it can be,' she says, 'it's best to lock up everything and put a rope on the roof to hold it down.' I put stakes in the ground and note that the rope used is decaying. A wind comes up and I see the shutters close. The storm passes. . ."

Stress is made on the family's unity and the special inviolacy of the self-mother relationship. This is secure against attack, although incest defense-formations are at this time weakening.

Separation—(urethral retreat)—". . . 'Where can I go? What can I do?' I cry. A whole lot of water reaches the building where I am. Just in time I reach a pond and get a rowing boat with oars. I grab them and set out, till I am challenged and stopped by a man. I duck down to escape. He orders me back . . . I go down to the basement thinking there would be no water there. I search for some valuable (jewel) left behind, but I change my mind and go out. I escape unnoticed as a screen door opens, I'm coming downstairs just as a woman goes up . . ."

The opposite note is struck here; the escape from the mother and the successful evulsion (weaning), on a pattern of the first separation dread (birth descent).

D. *Construction*—(genital security)—". . . I am bringing machinery for a generator working a windmill on top of a hill. This is better than operating spring water underneath, pumping from pipes underground. It is an ordinary system using sterile water with a lavatory at the bottom of house; I'm using same to raise crops. I thus save my seed to last 5 years. . ."

The conviction of immense potency and unusual continence derive from a sense of magic Power, source of perpetual fertility, whence the *device* for generating the seed. It represents a constant self-renewal at the instance of the divine fluid.

Destruction—(genital inadequacy)—". . . I'm working in a ditch putting big beams on outside walls, to hold it from caving in. Next, I am sawing away at a big tree they have cut down, and going to make beams of. It starts cracking and it comes toppling down over the ditch. 'Watch out!' somebody shouts. We all duck down just as the sides cave in . . . Voice: 'Gee, that's a narrow escape!' . . . "

Here destruction (on the infantile pattern) takes obvious castration form. Note the threat to erection, and the break-down of psychic defenses against anxiety.

E. *Discovery*—(somatic exploration)—". . . I see Hawaiian girls moving round a table. I'm having a hell of a good time drinking with some party and raising some disturbance. I'm doing a dance with a sporty girl, one complete with caps, strips and confetti. (Do men have double breasts too?' I ask)."

The recognition of sex differences comes after the child's latency phase; furtive advances to females are possible only in phantasy. There is no rebuff. Play is permitted.

Obscurity—(somatic concealment)—". . . Digging a new passage to the dormitory, as more room is necessary; crowds keep coming in. They are drilling in the boiler room. 'You can't drill through there,' I say. 'Where is the opening?' . . . There is no cell, but you'll see the outside from the back! . . . I was told you need hard tools to screw through, but I take the red handle of a big screw-driver to do so. . ."

The child's real need to follow the unknown places of the mother, which finds satisfaction in acts of boring and breaking in. The motif for the adult *crime* (breaking in) in these cases, is the premature discovery of the sexual secrets and the sexual object. There is little doubt, from frequent indication, that our patient was privy witness to coitus at an early age and interpreted it sadistically.

Inviolacy (*Introversion*)

The final degree is reached in the clinical picture where the patient can retreat completely from the sensate world. His phantasies at times reach a bizarre degree, and take the form of real regression and that the world no longer exists. He is alone and lives in a cell (motive for incarceration).

". . . A fort all around me, a western wall. I'm protected to 100 feet underground and all around are shields with automatic controls, electrically wired and made impossible for anyone to attack. None can harm *me*. Bombs can have no effect! I am in charge of a small security army . . . I can hold millions at bay, even if they murder me . . ."

From this mode of megaloid thinking it is not a far cry to cosmic representation and universal application of the primary theme. The precox conceives in terms of grave events, of moon, stars and comets,

but so far no adequate explanation has been forthcoming for these nebulous phantasies. We offer a possible understanding of this phenomenon in terms of projection mechanics.

COSMIC REPRESENTATION OF CONFLICT

There follow now some instances of primordial thinking in the course of the dream series, illustrating this other-worldly preoccupation.

I–*Earth*–". . . From miles away I see the world going about, the planets and the moon with spots on it . . . The earth comes spinning towards me, and a thought enters my mind 'why can there be no people on the moon, is not the earth flat after all', and other ideas."

II–*Planets*–". . . I am in the clouds amid a galaxy of stars, yellow and red, with lightning streaks floating around. I twist in the cloud with things like sparkling jewels (diamonds) about me on the stars."

III–*Ocean*–". . . Ocean flood water, wave upon wave, with me in my rowing boat. I duck down and get lost in the gulley. I am ordered back into the pool. The flood has vanished and I am on top of the waters."

IV–*Moon*–". . . Shot up from a gun several million feet, and next thing we are on top of the moon. I shout: 'Don't move, we need helmets! No. It's dry here!' We close the doors of our rocket, feel some air against us as we set out home. I tell my friend it's strange there are no people living there."

V–*Sun*–". . . I decide I will get some ship in air to withstand the temptations of the sun, specially arranged to go without shooting, by means of my strong fluid. It is some stone-work cell which I build, to shoot up and get close to the sun, as though people lived there in the jungle." (Our interpretation follows.)

COSMIC REPRESENTATION AND ITS UNDERLYING MEANING

The explanation of these phantasies of cosmos is that self projects onto the universe its unassimilated sensational impressions. More fully expressed, the interpretation is in terms of topical excitation zones. We are witnessing typical projection phenomena; for the 'other world' is equated with the Mother, or imago of Mother-Self within the Unconscious.

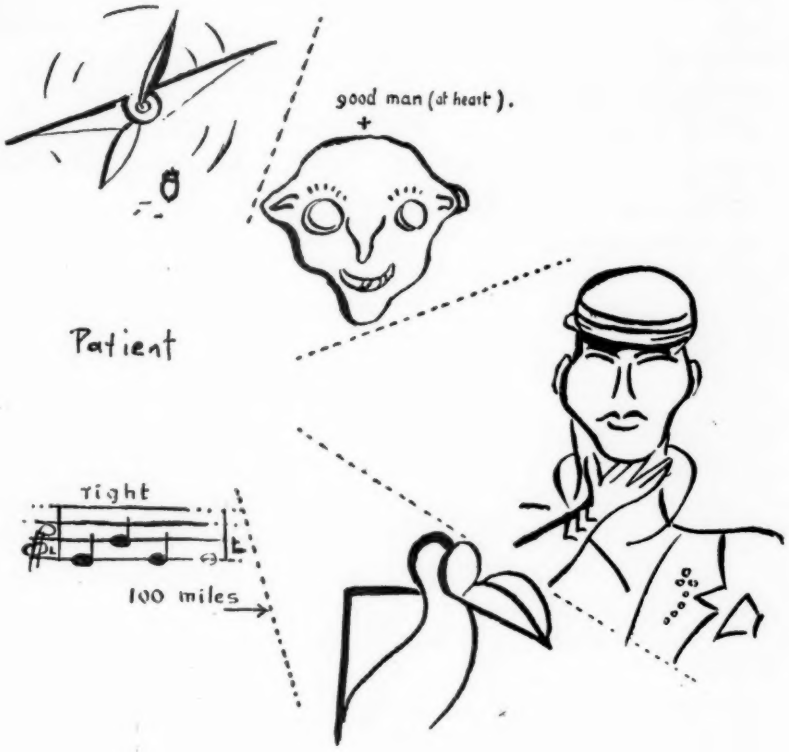


FIG I. Illustrating Instinctual Dichotomy.

I–*Earth phantasy*: reclaimed memory of the breast, with paresthetic hallucinations arising from hunger needs (probably an example of suckling orgasm).

II–*Planets*: color skotomata of retina produced under conditions of strain, e.g. transient hyperpiesis of excitement, drugs or from pressure on eyeballs, such as would occur in squeezing of eyelids, ipsation, stool-strain or hugging at the breast, etc., i.e. "seeing stars". (Evacuation orgasm).

III–*Ocean*: the "oceanic feeling" accompanying amorphous dread with any recurrence of infantile helplessness in instinctual resurgencies; a sensing of recurrent pulsations; the little self at the mercy of chaotic emptiness (of the bladder). (Urethral orgasm.)

IV–*Moon*: solitary isolation of the only child on the mother's lap, first realisation of security (from urethral accident) and equilibration disturbance; the sense of distance from *terra firma* in fear of tumbling, overlooking, etc. (Rocking orgasm.)

V–*Sun*: height and heat of passion achieved by ipsation; climactic elevation of spirits. (Manual orgasm.)

Self thus identifies first with own part-objects (e.g. penis), then external objects (nipple), and then projects them on to the external world (cosmos), as yet incompletely separated from the mother-self unity. The repudiation of incarceration and the aggrandising of the cell is nicely shown.

Part-Whole Symbolism and Identification

The language of the precox becomes meaningful in the light of its identifying systems. There follow some instances of part-whole identifications, which emphasize (without need for comment) the main dichotomy in thought processes. Note the ambivalent and ambisexual role assumed and the resulting intrapsychic conflict therein implied. We first give the dream with its most significant equations (numbered) and then offer a brief interpetation.

Dream: "This is a celebration for a man released from imprisonment, with other men wearing green pyjamas over brown suits, as in a mask or masquerade. They give the impression of being half-woman or. . .

man half-brute, and seeming to swim or dance at same time (1)
as in a big cabaret.

I carry to the hero a small piece of iron from the workshop
with two round wheels at each end (2) . . .

We try to smuggle him in and . . .
carry him off and bury him (3)
in a swamp across by the factory. That piece of steel we meanwhile throw over the fence. After cutting our way through with pliers . . .
we push the body through the hole, then cover up the wire (4)
and jump over.

The question is raised among others 'Where did this man go to?' 'Oh! he's gone for lunch,' I say. Meanwhile, I and the . . .
engineer carry the box; and all, eating at the same time (5)
look on, meanwhile, as if they were all 'in the know' except the overseers.

There is barbed wire and a tent covering over the gravery (graveyard ?); as it is a place of no escape, we just carried him there. We had not killed him, having merely
found him thus on the floor in the boss's room (6)

So I cry 'Let's put him
in an iron chest. He is very small, we can pack him in.' (7)

But the arms keep slipping out, then the head pops out and has to be put back. Again the question crops up:

'Shall we take this piece of steel and throw it over the fence (8)
or do you want to bury him in the swamp? No, in deep water,' they say."

(The interpretation of this follows.)

PART-WHOLE IDENTIFICATION: INTERPRETATION

Defective projection-identification mechanics partly explain the schizophrenic mode of thought here. Note in Equation enumerated

(1) Excitation resulting from observed erotic embrace; the uncertainty on the inter-sexual position. (skoptophilic)

(2) Sacrifice of the phallos to the father, who becomes thereafter the gratificatory object.

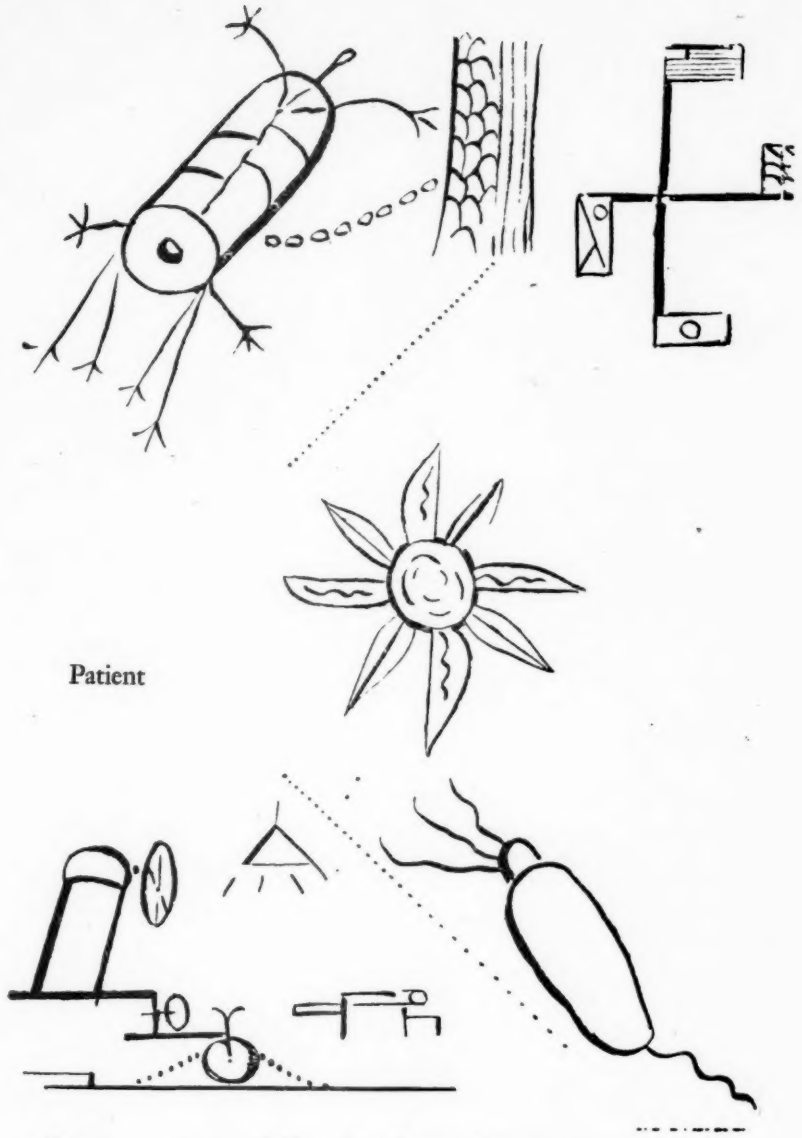


FIG II. Ambivalent Phantasy. Series.

THREE MEN (Gordian Knot motif)
PEACE (Union of opposites")
ROSE Mandala ")
INVENTION (perpetual motion")
LIFE (phallic ")

(3) Object (him and it) not of love but of hate, (ambivalency)

(4) Sadism, sodomy and status quo in a neat condensation symbol; (sado-necrophilia and restitution)

(5) Casket and lunch-box equated via tools; (oral cannibalism)

(6) Father victim of parricide; immunity to dreamer by invoked suicide (projection)

(7) Doll-foetus-phallos equation (sadistic coitus per anum)

(8) Anal discard and the repressing of spent aggression; (infant ipsation)

Thus *time present* is, for the precox, lived largely by virtue of the past, also by leave of the past and almost at the mercy of the past, whenever self is permitted to recapitulate the childhood scene. Thus the jack-in-the-box, elementary carpentry and other preoccupations, enhance, or revive, the child's experiencing again of all its instinctual aggressions. The dream life, phantasy life and much of our patient's ordinary conversation bore witness to this necessary restaging of the unlived out past.

Summary

Anachronism or projection onto the past of current realities in the disease, represents the subject's symbolic identification with pre-lingual phases of his development. It is especially well exemplified in the schizoid mentality by virtue of its deep psychic regression, involving the oral sadomasochistic stages, with oral restitution phenomena (including neologism) chiefly in evidence. The language of precox represents a sickness of the psyche just as disease of language culturally is a pure schizophrenic phenomenon, which is found to occur in periodic epidemics in society. This thesis illustrates the underlying schizoid phantasy life with reference to the equation *tongue-phallus-urethra-nipple-self*, as destructive object, a symbolism surviving the urethral sadistic phase. The primordial elements in the disease syndrome thus represent an anachronistic regression, deriving from defective identifications, outcome of conflict in connection with ambivalent intents, and the split which characterizes schizophrenia is primarily of this order.

25 Charles Street
Liberty, New York

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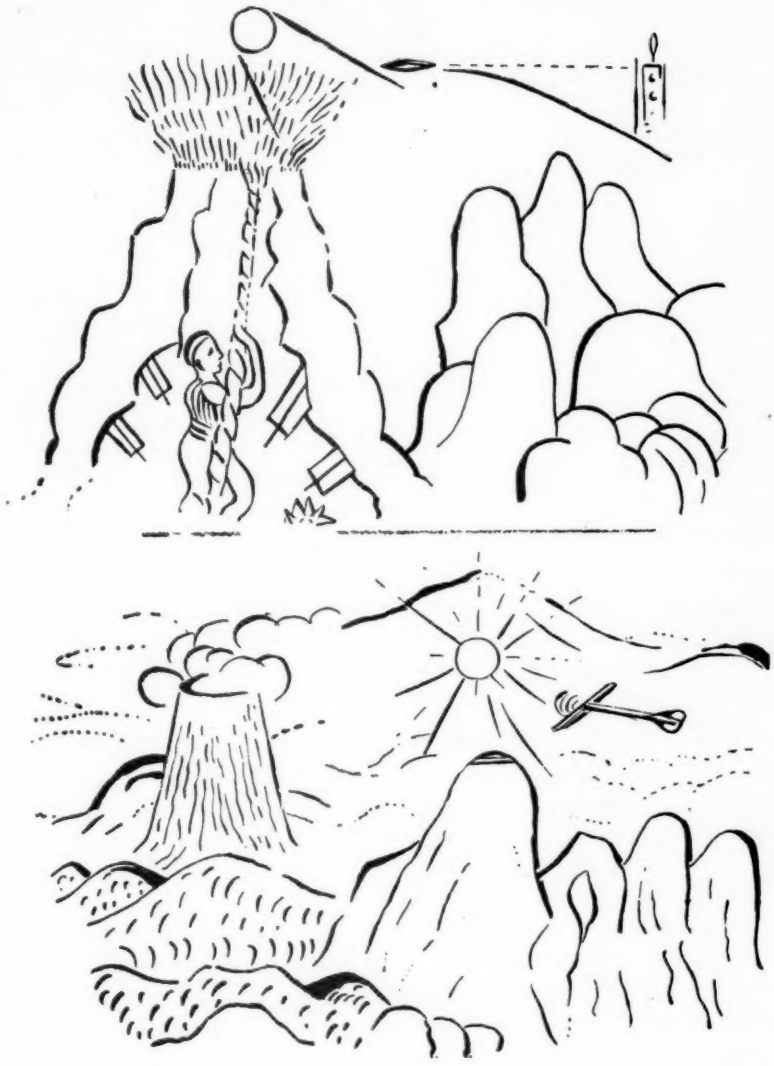


Fig. III. Urethral Annihilation Phantasy

Note the Aggressive Teeth and Belching Motif. (Patient's Association)

SOME INDIVIDUAL CORRELATES OF INSTITUTIONAL MALADJUSTMENT IN DEFECTIVE DELINQUENTS

SAMUEL B. KUTASH, M. S.

Woodbourne, New York

INTRODUCTION

In the new penolog[y] [i]nstitutionalization or imprisonment is thought of primarily as a protec[tive] measure for society and for the incarcerated individual and not from the point of view of punishment for the criminal. The institution or prison must provide such care and treatment as will help rehabilitate the inmate so that he can later be returned to the community to lead a useful, normal life. A fundamental prerequisite to such rehabilitatory training is the adjustment of the individual to the institution and its program. Without this, treatment cannot take place. And yet, few attempts have been made to study institutional adjustment, to identify, describe and determine the relative importance of the individual correlates which are associated with it, and to elaborate a practical procedure for detecting, among new arrivals, the early signs of possible institutional maladjustment and future behavior problems.

The problems are extremely complex and the whole success of the institutional program depends upon their satisfactory solution. What the signs and results of institutional maladjustment are, seem to be well known to wardens, superintendents, assistant superintendents and prison keepers, but the motivating factors and the antecedents of such maladjustment are not clearly understood and need clarification. The present investigation will, it is hoped, contribute to a greater understanding of the causes and motivating factors of institutional maladjustment of inmates and to the diagnosis of prospective inmate problems, so as to prevent some disciplinary cases from arising to interfere with the institutional program. No completely satisfactory attack upon this problem has yet been made.

Some earlier studies such as that of Branham, "Behavior Disorders in Prison,"[3] in which a classification of behavior disorders was suggested into the sustained tension group, the rythmically recurring tension group and the unpredictable tension-release group, and that of Brooks[4] in which a technique was tried out for the detection of behavior maladjustments in prison, have contributed to a recognition of the problem and the beginnings of the search for solutions.

Institutional maladjustment may be thought of as a continuation by an offender of his anti-social conduct *even after* incarceration. Thus, Weinberg[22] points out that in prison, conflicts between criminals and law enforcing agencies persist in modified form. It would be caused by the very factors in the individual's psychological make-up and environment, which originally made him an offender against society's laws and also by the institutional set-up, the individual's reaction to it and the effects of incarceration.

This paper consists of a comparison between an institutionally "maladjusted" group of defective delinquents and an institutionally "well adjusted" group, for a variety of factors which might be correlates of maladjustment in the institution. It is preliminary to a larger research study in which it is proposed to study the effects of the institutional set-up itself on institutional behavior, to construct and standardize an institutional adjustment questionnaire, to determine its value for diagnosis and prognosis of new inmates and to measure the individual personality characteristics and their manifestations in the institution.

Procedure in Collecting and Using Data

In order to set up the groups for comparison, the conduct files of the institution were consulted. The conduct and behavior reports of all inmates who have been in the institution for at least three years, were reviewed. There were about 400 such inmates. Those with the greatest number and the most serious reports of disciplinary action were considered for the "maladjusted" or M group. These were gone over with the Assistant Superintendent who, as a disciplinary officer of the institution, knew most of the seriously maladjusted inmates well, and those cases with many trivial reports were weeded out.* The judgments of

* The advice and guidance of the Assistant Superintendent, Mr. Edward M. Fay, was extremely helpful in this connection.

the Superintendent and other administrative officers were also utilized, since they were most familiar with the chronic offenders aganst institutional authority. In general, a high correlation existed between number and seriousness of the reports, since the most serious offenders also offended most often. Those with absolutely no conduct reports since they came to the institution were placed in the "adjusted" or A group.

The M group thus contains 50 inmates who frequently violate institutional rules, are continual behavior problems in the judgment of the uniformed and professional personnel, and are sources of annoyance to the other inmates and to the administration. They are the 50 *most serious disciplinary cases* in the entire institution. The A group contains inmates with excellent conduct records while in the institution (*no conduct reports at all*), who are well liked by the personnel and perform useful work in the institution. There were only 45 such inmates available.

Nature of the Data

Information secured from interviews with inmates, probation and parole reports, psychiatric reports, questionnaires sent to various informants, physical and psychological examinations and other sources were utilized in this investigation. Institutionally "maladjusted" inmates (M group) were compared with "adjusted" inmates in the following factors:

A. Chronological Age
B. Mental Age and Intelligence Quotient
C. Marital Status
D. Racial Origin or Nativity of Parents
E. Religious Denomination
F. Family Background
G. Number of Siblings
H. Incidence of Broken Homes
I. Schooling
J. Occupation Prior to Incarceration
K. Nature of Crime for Which Committed
L. Number and Types of Previous Crimes

M. Incidence of Recidivism
N. Term of Sentence
O. Number of Other Institutions inmate was in
P. Psychiatric Diagnosis
Q. Sex Habits
R. Use of Alcohol and Narcotic Drugs
S. Incidence of Venereal Disease
T. Number and Kind of Physical Illnesses

RESULTS

The results are presented below under each heading:

A. *Chronological Age:*—The M Group showed a range in C. A. from 23 to 58 years of age with a mean at 32.66 years, whereas the A group ranged from 20 to 67 years old with a mean at 45.53 years. The "adjusted" inmates were thus an *older* and more *heterogeneous* group than the "maladjusted." (See Graph I).

Recent data shows that young people furnish more criminals than their frequency in the population warrants. Reckless[15] in his work on "Criminal Behavior", points out that in the 1930 census, the age group 20 to 24 comprised 8.9% of the population of the United States; but 20.4% of the arrests in 1937 were within that age range. On the other hand, the age groups over 50 contained 17.2% of the population but only 8.7% of the arrests.

In their book on frustration and aggression, Dollard, Doob, Miller Mowrer and Sears,[8] have pointed out the possibility that crime may tend to be a youthful occupation because, with age, the individual becomes settled in society, his level of frustration generally decreases and his responsiveness to the threat of punishment becomes greater. This hypothesis may be used to explain our findings. If the institutional set-up is considered a society, and Haynor and Ash[11] so consider it, the older inmates become more settled in it, their level of frustration decreases and they are more responsive to the threat of punishment which is always present. They, therefore, less frequently become behavior problems in the institution.

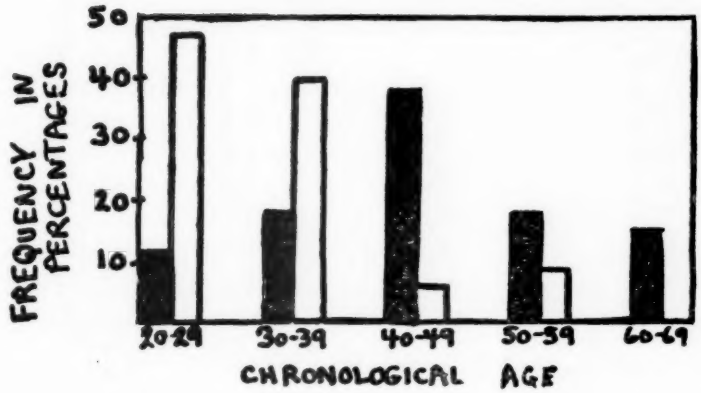
Another point to be considered is that crimes against property or the acquisitive crimes have more than their proportionate share of youthful perpetrators and, as we shall see later, these are more frequently found in the M group.

Graphic Presentation of Results

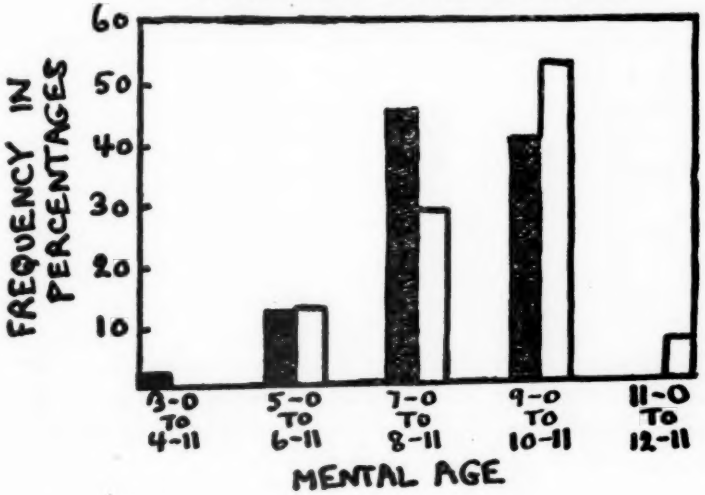
Graph I - Chronological Age

Group A - Black Bar

Group M - White Bar

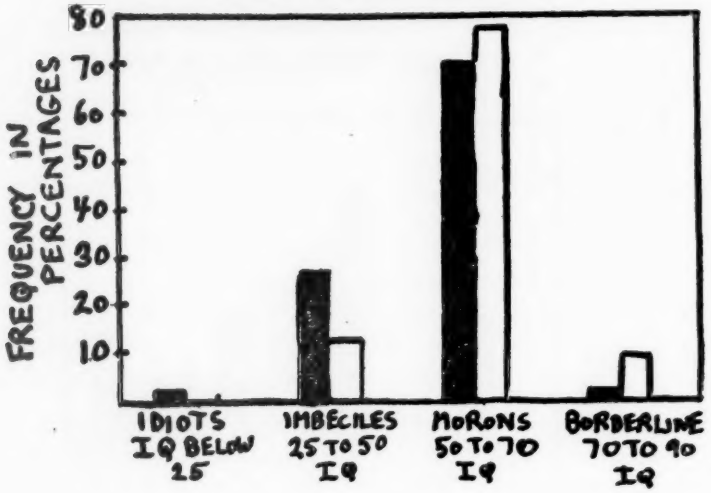


Graph II - Mental Age

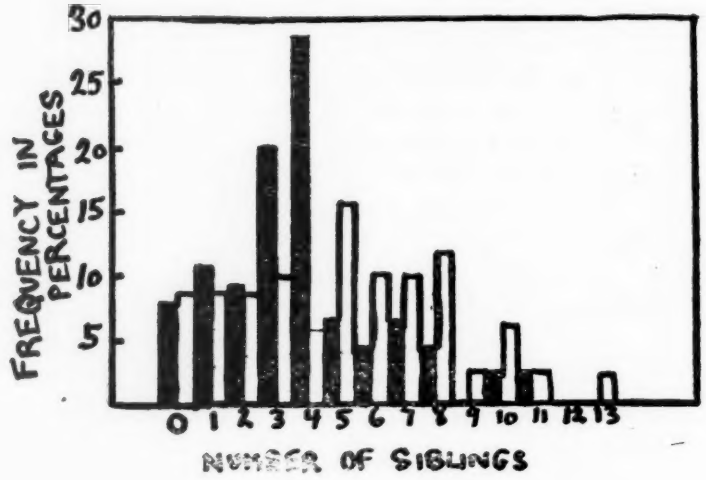


GRAPH III - INTELLIGENCE

GROUP A - BLACK BAR
GROUP M - WHITE BAR



GRAPH IV - NUMBER OF SIBLINGS



B. *Mental Age and Intelligence Quotient*:—All of the subjects were, of course, previously diagnosed as mental defectives. Still it was felt worthwhile to compare the two groups as to mentality. The mental ages of the M group ranged from 6 years, 6 months to 11 years, 11 months with a mean M. A. of 9.023. In the A group, the mean M. A. was 8.352 with a range of from 3 years, 4 months to 10 years, 9 months. (See Graph II). The mean I. Q. for the M group was 60.4 and for the A group 54.82. The ranges in I. Q. were from 42 to 79 for the M group and from 20 to 72 for the A group. The average intelligence quotient of our "maladjusted" inmates was thus higher than that of the "adjusted" by 5.58 points.

If we use Terman's[20] classification of the feebleminded into morons (50 to 70 I. Q.), imbeciles (25 to 50 I. Q.) and idiots (I. Q. below 25), we find that the M group has 10% (5) borderline cases, 78% (39) morons, 12% (6) imbeciles and no idiots. The A group has 2% (1) borderline cases, 70% (31) morons, 26% (12) imbeciles and 2% (1) idiot. This emphasizes that the M group has few imbeciles but consists mainly of borderline and moron cases while the A group has a substantial number of imbeciles. (See Graph III)

This result, although not marked, is consistent with previous findings in related studies. Ackerson[1] found that among pre-adolescent children, the average number of behavior difficulties increased with I. Q. level especially among conduct problems. Since, as will be shown later, the A group has a larger number of sex offenders than the M group and the M group has a greater number of perpetrators of acquisitive crimes, this factor may partially explain the I. Q. differences. Sutherland's summary of studies[19] led him to believe that type of crime is somewhat affected by intelligence. For crimes grouped into general types, he thought it safe to regard those convicted of crimes of acquisition as a relatively superior group and those convicted of sex crimes as a relatively inferior one.

C. *Marital Status*:—In the M group, 96% of the inmates were single although their average age was 32.66 years and 4% were married. In the A group, 69% were single and 31% married. (See Graph X). Thus, married men are more likely to be found among the "well adjusted" in prison or at least to show fewer overt behavior difficulties. The married inmates may have an added incentive for getting time off for good behavior because they have a family with whom they correspond and to whom they wish to return as soon as possible.

D. *Nativity of Parents or Racial Origin*:—In the M group, there were ten nationalities represented — 13 Italian, 10 American Negro, 8 American, 5 Russian, 4 Irish, 3 French, 3 Lithuanian, 2 German, 1 Swedish and 1 Czechoslovakian. In the A group there were also ten nationalities — 11 American, 8 American Negro, 7 Irish, 5 German, 4 Italian, 3 French, 2 Polish, 2 Dutch, 2 Austrian and 1 English. In this tabulation, an inmate was placed in a given nationality group if his parents were born in the country designated. Most of the subjects in both groups were native born sons of foreign born parents.

It is interesting, although it may not be significant, that the M group has a large proportion of Italian and American-Negro, both of whom show the highest proportionate crime rates. However, it must be pointed out, that with other related factors held constant, it appears likely that membership in a given race or nationality would not be correlated with crime. Still, some investigations have indicated that the crime rate of the children of immigrants is higher than that of the children of native-born whites and of immigrants (Caldwell[6], Sutherland[19], Sellin[17]). In our results, the rate of overt behavior difficulties in an institution, of children of immigrants, seems to be very slightly higher than that of the children of native-born whites. The M group has 84% children of immigrants or American-Negro and only 16% native-born whites. The A group has 76% and 24% respectively.

Armstrong[2] found that in proportion to the population of each group, the Italians showed nearly double their expected crime rate, the Russians exceeded theirs, and the Negroes tripled their expected crime rate. In an institution for defective delinqunts, these groups continue to make a disproportionate contribution to disobedience, violation of laws and rules, etc.

E. *Religious Denomination*:—In the M group, there were 56% (28) Catholics, 34% (17) Protestants and 10% (4) Hebrews. The A group was composed of 53% (24) Catholics, 36% (16) Protestants, 11% (4) Hebrews and one other; (See Graph X). There seem to be *no significant differences in religious denomination* between the maladjusted and adjusted groups, since their proportions are about the same. It is likely, however, that the difference occurs rather in the faithfulness with which the particular religion is observed, no matter what that religion is. A later study will interest itself, among other factors, in the degree to which the members of each group attend religious services and observances. The preliminary data show that it may be a stabilizing influence

making for better institutional adjustment when an inmate has faith in God and observes his faith.

F. *Family Background*:—To secure the data on family background the case history of each inmate was examined for evidence of the occurrence of insanity, desertion, feeblemindedness, alcoholism, nervous conditions, epilepsy, immorality, delinquency and behavior problems. Parents, siblings and grandparents were considered members of the family group.

In the M group 18 had "normal" family backgrounds with none of these factors occurring; 9 had histories of alcoholism for one or more members of the family; 8 had histories of desertion; 7 had feebleminded relatives; 6 were from families tainted with insanity; 6 with delinquency; 4 epilepsy; 4 immorality and prostitution; for 2 there was no available information; 1 with "nervous" condition; 1 with behavior problems. In the A group, 19 had "normal" family backgrounds; 13 had histories of alcoholism; 6 feeblemindedness; 5 no information; 4 desertion; 3 insanity; 3 immorality; 2 delinquency; 2 venereal diseases; 2 suicides; 1 epilepsy and none with behavior problems or nervous conditions. These figures should be regarded as minima since frequently the informants are reluctant to admit the occurrence of such factors in the family history.

Family background *does not seem* to be an important factor in whether an inmate will be institutionally "maladjusted". Both A and M groups show a greater degree of inferior backgrounds than their normal fellows.

G. *Number of Siblings*:—The mean number of siblings in the M group equaled 5.10; in the A group, 3.90. Thus the "maladjusted" inmates tended to come from slightly larger families. (See Graph IV).

H. *Incidence of Broken Homes*:—In the M group, 50% (25) of the inmates came from homes in which one or both parents were absent through death, desertion, divorce or other causes, before the inmate was 16 years of age. In the A group, 66.67% (30) were from broken homes. (See Graph X). The broken home as an etiological factor of crime is of slightly greater occurrence in the "adjusted inmates."

I. *Schooling*:—In the M group, 2 subjects had no schooling at all, while the rest left school at a mean age of 14.10 years having attained an average grade of 4.63. Five only reached the ungraded class. In the A group, 12 inmates had no schooling at all, 4 were in ungreded classes and the remainder left school at a mean age of 14.12 years having attained a mean grade of 3.63. Previous schooling seems to have little re-

lation to institutional adjustment. Both groups are uniformly low and there is not much difference between 3d grade and 4th grade achievement and the slightly higher average achievement level of the M group can be wholly explained by mental level.

J. *Occupation Prior to Incarceration*:—An analysis of the pre-institutional occupations indicates that both M and A groups had a large percentage of unskilled laborers. The M group breakdown showed 25 laborers, 7 with no previous occupational experience, 6 farm hands, 2 odd job workers, 2 seamen, 2 helpers and 1 each of chauffeur, deliivery man, counterman, peddler, bootblack and waiter. The A group distribution had 25 laborers, 8 farm hands, 4 helpers, 3 porters, 2 with no experience, 2 odd job workers, 1 polisher, 1 painter, 1 cook, 1 lumberjack, 1 peddler and 1 broom maker.

K. *Nature of Crime for Which Committed*:—The types of crimes committed were grouped under 5 headings: acquisitive crimes, assaultive crimes, sex crimes, arson and disorderly conduct. Table I gives the results:

TABLE I

	M Group		A Group	
Type of Crime	No.	%	No.	%
Acquisitive	36	72	19	45
Assaultive	5	10	5	12
Sex	5	10	12	29
Arson	3	6	1	2
Disorderly Conduct	1	2	5	12

There is shown in these figurse significant differences in the proportions of acquisitive crimes and sex crimes as well as trivial offenses. The M group showed a higher relative incidence of acquisitive crimes while the A group showed significantly more sex crimes and trivial offenses, grouped under disorderly conduct, than the M group. (See Graph V).

The greater number of acquisitive offenders who became institutionaly "maladjusted" may be explained partly by the frustration-aggression hypothesis of Dollard and Doob. The acquisitive criminal is one who may be motivated by "goal" behavior, trying to acquire something by anti-social means. His arrest and incarceration serves as a frustrating agent, preventing him from achieving his goal. He then

may develop aggressive and assaultive reaction patterns in prison. This is borne out by an analysis of the types of their misconduct, which includes mainly assaulting other inmates, insolence to officers, violating rules, refusing to work without remuneration, etc. The acquisitive criminals in the A group react to frustration not by developing overt behavior problems, but by regression. They become withdrawn, introverted, individuals of the submissive type. The sex criminals, on the other hand, tend to find outlets within the institution, in the form of masturbation, or sublimate their energy in the institutional recreational, educational and vocational programs.

Sutherland's summary of studies[19] led him to believe that type of crime is affected somewhat by intelligence. He stated that those convicted of fraud are usually a more intelligent group and that sex offenders are generally a less intelligent group. Evidence was inconclusive for other specific offenses. For crimes grouped into general types, he thought it safe to regard those convicted of crimes of acquisition as a relatively superior group and those convicted of sex crimes as a relatively inferior one. These conclusions are confirmed in the study of Frank of 401 male delinquents[9]. In his group, assault, rape and other sex crimes tended to occur most frequently among the lowest grades of intelligence. Charles[7] in his study of reform school boys and Hill[12] in his study of 1285 young male offenders, drew the same conclusions. Further evidence in this direction was presented by the Gluecks[10] in their study of 1000 delinquents. It is interesting that our A group has a lower I. Q. and M. A. and also a higher incidence of sex crimes and a lower occurrence of acquisitive crimes than the M group.

L. *Number and Types of Previous Crimes*: — The same relationships obtained here as under the consideration of the type of crime for which the inmate was serving a sentence. In addition it is noteworthy that the M group had 252 previous crimes recorded, or an average of 5.04 per inmate, whie the A group had a total of 152 previous offenses with a mean of 3.62 per inmate. The offenses included acquisitive, assaultive, sex, arson, disorderly conduct, juvenile delinquency, escapes, parole violation, vagrancy and truancy. A new factor was that while the M group had a 1% incidence of vagrancy, the A group had 11%.

M. *Incidence of Recidivism*:—For the purposes of this analysis, an inmate with more than 3 offenses in his past criminal record is called a *recidivist;* with 2 or 3 offenses, an *occasional offender;* and wth one of-

fense, a *first offender.* On this basis, the M group shows 72% (36) recidivists, 22% (11) occasionals and 6% (3) first offenders. The A group shows 38% (17) recidivists, 35% (16) occasionals and 27% (12) first offenders. There is conclusive evidence that recidivists are more likely to be among the maladjusted inmates. (See Graph VI).

Tolman[21] in a study of attitude differences between recidivists and first offenders, found, by the use of an oral questionnaire, that the recidivists made statistically significant higher scores in political insurgency, "chip on the shoulder," antagonism toward authority and lack of integration with ideal.

N. *Term of Sentence*:—The M group had 68% (34 inmates) with indefinite sentences and 32% (16) with definite terms ranging from 5 to 20 years. The A group had 44% (20) with indefinite sentences and 56% (25) with definite sentences ranging from 5 to 30 years. (See Graph X). It may be that an indefinite committment serves as a frustrating factor leading to aggressive misbehavior on the part of inmates.

O. *Number of Other Institutions Inmate Has Been in*:—A tabulation of the number of different institutions the inmate has been in prior to his present incarceration discloses that the M group had an average of 3.20 per inmate while the A group had a mean of 2.33 per inmate. The accompanying graph shows the actual distribution, indicating that in the A group there were few who had a large number of previous institutionalizations whereas, in the M group there are a substantial number with many institutionalizations. (See Graph VII).

P. *Psychiatric Diagnoses*:—Each inmate was given, at some time during the beginning of his present incarceration, one or more psychiatric examinations for classification purposes. An analysis of these reports indicated that in the M group, 52% (26) were diagnosed as psychopathic personalities, 10% (5) as psychotic (2 manic depressive and 3 dementia-praecox), 8% (4) suffering from epilepsy, 2% (1) post-encephalitic, 2% (1) pathological liars, 4% (2) pyromaniacs, 2% (1) emotionally deteriorated and 20% (10) showed no marked psychiatric difficulties besides their mental deficiency. Of the psychopaths and other classifications, 11 inmates were considered potentially psychotic and 19 as emotionally unstable.

In the A group, 80% (36) were found to be free from any marked deviations which would classify them as psychopathic personalities, psy-

chotic, emotionally unstable, epileptic or deteriorated. Of the remainder, 6.7% (3) were diagnosed as psychopathic personalities, 8.9% (4) as psychotic (1 manic depressive and 3 dementia praecox), 2.2% (1) as epileptic, 2.2% (1) as emotionally deteriorated. (See Graph VIII).

The contrast here is so marked that it seems that the greater proportion of institutionally "maladjusted" inmates are psychopathic personalities, psychotics or emotionally unstable. It is significant that most of the examinations were made at the time of classification when the inmate first began his present sentence and before he was a known behavior problem in the institution. Butler[5] states that according to definition, defective delinquents are subnormal intellectually, have decided anti-social tendencies and possess definite psychopathic attributes. This definition only holds for our M group according to our results.

Q. *Sex Habits*:—In the M group 26% (13) were normal in their sex habits, 28% (14) were perverted and practiced sodomy, fellatio or other perversions at some time, 2% (1) had a prior record of indecent exposure, 8% (4) were chronic masturbators, 24% (12) led extremely promiscuous sexual lives and concerning 12% (6) there was no reliable information about their sex habits.

In the A group, 48.9% (22) had normal sex habits, 22.2% (10) were perverted, 2.2% (1) had a record of indecent exposure, 4.5% (2) were chronic masturbators, 13.3% (6) were sexually promiscuous and concerning 8.9% (4) there was no information. (See Graph IX).

In spite of the fact that the A group had a greater incidence of sex offenders, as a group they had less perverts, less chronic masturbators, etc.

R. *Use of Drugs and Alcohol*:—There was only one known narcotic drug addict in the M group and 2 in the A group so that this is not a significant factor. The M group had 36% (18) with histories of alcoholism while the A group had 37% (17) so that, here too, there is no significance to be attached to this factor. Selling, in a study of the role of alcoholism in the commission of sex offenses[18], reached the conclusion in his clinical data that individual psychopathology is of greater importance in motivating sexual crime than alcohol itself.

S. *Incidence of Venereal Diseases*:—A tabulation of the number of cases of syphilis and gonorrhea indicated that in the M group 20% (10 inmates) had histories of syphilis while 16% (8) inmates had his-

tories of gonorrhea. In the A group, 13% (6 inmates) had syphilis and 9% (4) had gonorrhea. There is thus a slightly higher venereal disease rate in the M group. (See Graph X).

T. *Number and Kind of Physical Illnesses*:—A tabulation of physical illness and defects excluding venereal diseases and very minor illnesses such as colds and measles, showed that the M group had a total of 151 defects and illnesses listed in their developmental and medical histories or an average of 3.02 per inmate. The A group had a total of 87 or 1.93 per inmate. Table II shows the complete tabulation.

TABLE II

ILLNESS OR DEFECT	M GROUP	A GROUP
Acne	4	2
Amputated Digit	1	0
Appendicitis	8	1
Atrophied Testicle	2	0
Arteriosclerosis	1	1
Balanitis	1	0
Bubo	1	0
Cardiac Disease	5	6
Cellulitis	2	0
Crushed Sternum	0	1
Deafness	3	5
Deviated Septum	2	0
Dizzy Spells	4	3
Dermatophytosis	1	1
Diphtheria	3	2
Eczema	3	1
Endocrine Disturbance	1	3
Fistula	1	1
Gall Bladder Disease	0	1
Gastritis	1	0
Head Trauma	9	5
Hemorrhoids	6	7
Hernia	14	4
Hydrocele	0	1
Hypertension	1	3
Infantile Paralysis	2	2
Influenza	3	0
Interstitial Keratitis	1	0
Kidney Disease	1	1
Malaria	1	0
Marked Enuresis	9	1
Mastoiditis	1	1
Meningitis	3	0
Otitis Media	6	0
Penis Deformity	1	1
Pes Planus	3	1
Pleurisy	2	0
Pneumonia	9	4
Pulmonary Tuberculosis	4	3
Pyorrhea	0	4
Rheumatic Fever	2	0
Rickets	6	1
Scarlet Fever	2	1
Scoliosis	1	0
Sleeping Sickness	1	0
Speech Impediment	7	4
Teeth Decayed	2	4
Typhoid Fever	2	1
Varicocele	2	0
Varicose Veins	2	3
Vision Defective	5	6
TOTAL	151	87

Norman[14] compared inmates of a Federal Reformatory, who were reported by a physician as attending sick call frequently, with an unselected fraction of the institutional population. They were found significantly more often difficult to handle in prison and were judged potentially worse prospects for civil life. A large number of studies of physical traits and crime have been published recently, investigating both the physical characteristics of offenders and the incidence of criminals and delinquents in groups with physical disorders. E. A. Hooten[13] has gone so far as to state that the primary cause of crime is biological inferiority. This, however, may be too sweeping a conclusion. Evidence that there may be a biological factor predisposing to crime has been given by Rosanoff, Handy and Rosanoff[16]. That physical defects are significant to criminals in some cases because of the effect of the ridicule of others, has been suggested by Sutherland[19].

Inferences and Conclusions

This paper is but a *preliminary* and *exploratory* attempt to evaluate those factors in the defective delinquent's physical, mental and social equipment which might affect his adjustment when he is institutionalized or incarcerated. It is difficult to draw completely positive conclusions concerning the causative value of any one factor when a constellation of many factors operates to determine institutional "adjustment." This limitation added to the relatively small size of the two groups (even though this study covered all the available cases) makes prediction of the institutional adjustment of an inmate difficult.

Bearing these limitations in mind we may note that the following seem to be highly significant factors which are concomitants of institutional 'maladjustment": nature of crime for which committed, number and type of revious crimes, incidence of recidivism, term of sentence and most important, psychiatric diagnosis. Of some significance are chronological age, marital status, number of other institutions the inmate was in, sex habits, and number and kind of physical illnesses. Mental age and intelligence quotient, racial origin or nativity of parents, number of siblings, incidence of broken homes and incidence of venereal disease show only slight differences. No differences at all are shown by religious denomination, family background, schooling, occupation prior to incarceration and use of alcohol and narcotic drugs.

For predictive purposes, a system of weighting of the factors could be devised in which each factor could be assigned a weight in proportion to the size of the differences shown in it between the M and A groups. Thus, psychiatric diagnosis would be weighted highest and use of drugs and alcohol, lowest, etc. Practically, the occurrence of a high weighting in one or two factors alone for an individual would not be conclusive but when the Superintendent, Assistant Superintendent or disciplinary officer notes that a new inmate is diagnosed by the psychiatrist as a *psychopathic personality*,, that he is committed for an *acquisitive crime*, is a *recidivist*, has an *indefinite term of sentence* and many previous offenses, he can conclude that the chances are that the inmate will be *difficult to handle* in the institution and that he may become a behavior problem. A suitable program can then be decided upon taking these factors into account. Inmates of ths type will need special handling.

Summary

Two groups of "maladjusted" and "well adjusted" defective delinquents respectively were compared for 20 factors to determine the possible significance of these factors for institutional adjustment. Of the 20 factors studied, psychiatric diagnosis, term of sentence, recidivism, nature of the crime and number and type of previous crimes were found to distingush best between the two groups. Mental status, C. A., number of other institutions the inmate had been in, sex habits and number and kind of physical illnesses, were of moderate significance. Of slight significance were racial origin or nativity of parents, M. A. and I. Q., number of siblings, incidence of broken homes and incidence of venereal disease. Religious denomination, family background, schooling, occupation prior to incarceration and use of alcohol and narcotic drugs showed no differences between the two groups.

These findings can be utilized by institutional administrators in classifying inmates in accordance with their possibilities for institutional "adjustment" which is a prerequisite for effective treatment. A system of classification can be devised, based on a weighting of the factors in accordance with their significance.

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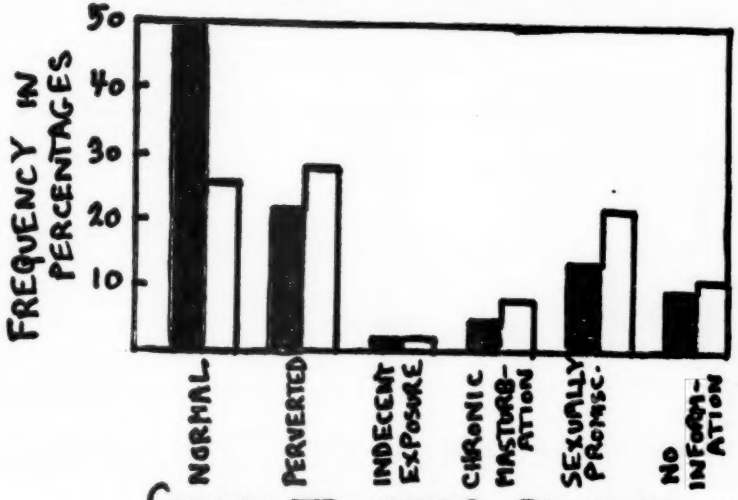
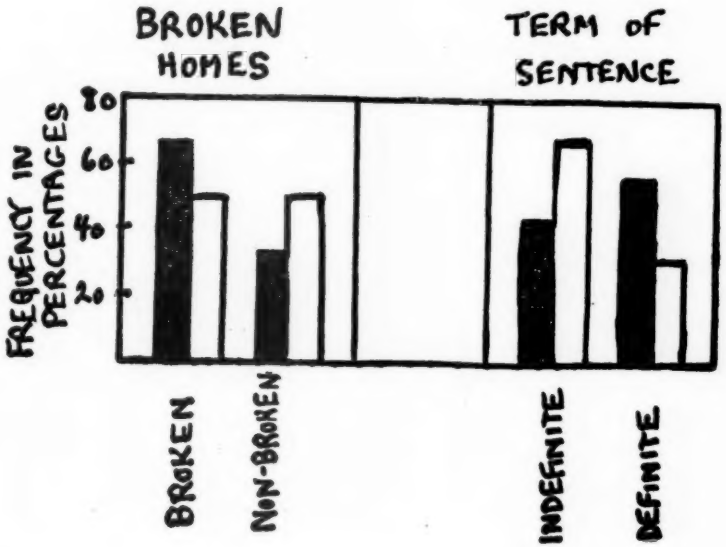
GRAPH IX - SEX HABITS

GROUP A - BLACK BAR

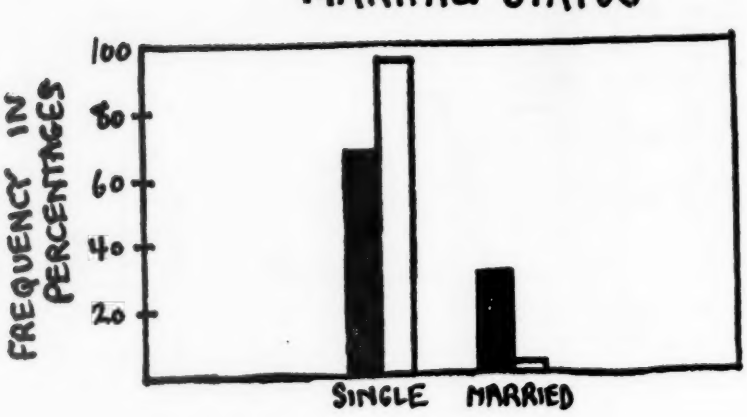
GROUP M - WHITE BAR

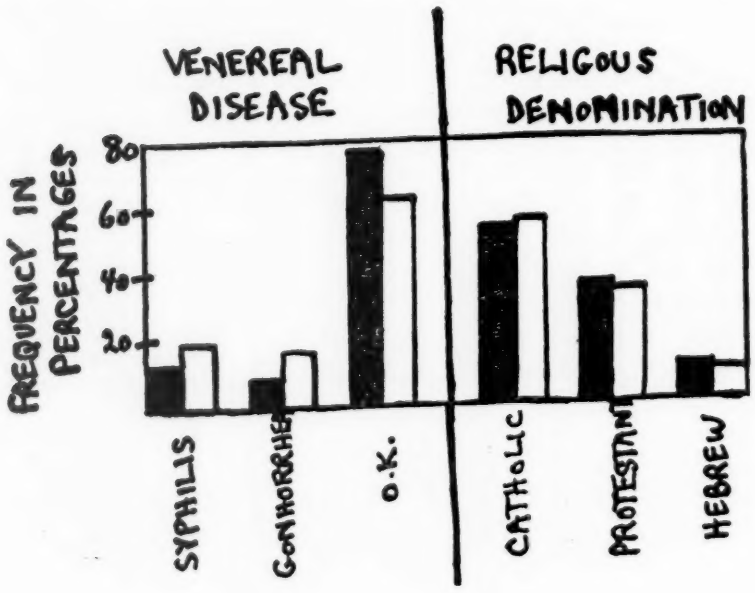


GRAPH X - OTHER FACTORS



GRAPH X - OTHER FACTORS
(CONTINUED)
GROUP A - BLACK BAR
GROUP M - WHITE BAR





REACTIVE AGITATION AND MANIA

ARTHUR N. FOXE, M. D.

New York City

In psychoanalysis the tendency is to focus the attention of the patient on himself. The assumption in this maneuver is that the illness is closely related, causally, with conflicts of infancy and childhood. The subsequent discovery of such conflicts is by no means an earnest that the illness was the result of these conflicts.

A man may take to drinking. Childhood conflicts very well may contribute to his new tendencies. He goes into a low dive, is accosted and struck on the head with a bottle, thereby sustaining a laceration of the scalp and a fractured skull. If he happens to be under analysis at the time of this unfortunate episode, the analyst might correctly say that the childhood conflict and the fracture were causally related; this would be like the parent whose first reaction to a child's bruise might be, "Didn't I tell you not to play with Billy?" However, the surgeon will repair the laceration and aid the body in healing the fracture. The police will not piddle about but will take the assaulter in hand and he very likely will stand trial. The defense might say that if the victim had not had a disturbed childhood, he would not have been a drinker, could not have been drunk and in the said barroom, could not have been assaulted and hence there would have been no question of a crime. This sounds absurd. The defense might claim further that the *vita ante acta* of the defendant was immaculate. The defendant always had lived a law-abiding existence, was married, had three children, always supported his family, and had never taken more than one drink of an evening until the day of the assault. That momentous afternoon he had been notified by his employer, with whom he had been for fifteen years, that it was necessary to dismiss him because of economic problems in the company. The defendant had controlled his anger against his employer, but uxor-

ious, ashamed, and distressed, something had kicked the beam. He did not go home but went instead to two bars and rather lost control of himself after six drinks. At this point the story is less absurd. Should the victim receive a greater justice because the origins of his drinking lay in his childhood, or should the defendant have a benign quittance because his drinking was caused by a more immediate injury in the field of morale? It is conceivable that if courtroom procedure investigated into the childhood and ancestral history of each plaintiff and each defendant, it would make the prescient face of justice blush and it would be exceedingly difficult to have any real judicial rendering of a verdict. But here we are not concerned with justice as such but more with diagnosis, and hence therapy.

It has been suggested, above, that the analytic method, probing ever more deeply into the individual's life, leads one eventually, to hold the patient blameless for his behavior and to place the responsibility for behavior upon the parents. By logical sequence this is correct. Following this logical sequence, it is to be noted that today, judges more frequently hail parents into court, claiming that young people are too delinquent because of the training they received at the hands of their parents. The parents may be warned or punished. The effect of this is highly problematical and often must antagonize both child and parent against the law. It is to be observed that the only practical result of analytic knowledge in such an instance, becomes the displacement of punishment, without assurance that the punishment is at all helpful. That the parent is blamed is not, on second thought, due to the fact that the parent is at fault, but due to the fact that punshment of the criminal, in the first place, has failed to achieve results, that for some reason the crupper institution of punishment must be scrupulously maintained, and that so many juveniles cannot be punished without damaging the morale of the whole nation. In other words, scientific data that indicate the futility of punishment are utilized to rationalize the inflicting of punishment, very much as inventions designed to promote peace soon are converted for the waging of war.

It is conceivable that an unflinching parent who is blamed, might in turn claim that it is beyond his ability to control his child and that the child must be at fault. The parent is analyzed in turn and it is discovered that his inability to control his child is due to his childhood

training and certainly he is not at fault. Unfortunately his parents are dead and whom is one to punish. At this point there might be some quandary, but the judge might say the whole heredity is bad and the child should be destroyed lest he some day produce offspring. So strong is the self-pluming compulsion to punish. One can go one step further and then it is no longer a matter of heredity but race itself. Sometimes one must wonder at the quaint generosity of the scientist who gives his discoveries, without cost, to be used in ways incredible to him. Perhaps the essence of genius lies in revenge. Perhaps the scientist should retain some control over his creation even though he might not materially profit therefrom. But these are curious illusions in which the writer has no real belief. They do serve as a convenient introduction and approach, however, to the problem of reactive agitation and mania.

Our defendant certainly does not appear to have acted like a patient suffering from manic-depressive psychosis, schizophrenia, or any of the well-known psychoses. It would seem that he was unduly agitated by the awful lot that had befallen him or seemed impending; the peaceful animal attacked unawares. His behavior would be the result of a reaction to a real blow, in addition to which was added the effect of alcohol on his inhibitions. An examination of his past life and origins might indicate that he could not have had too great a nervous reserve. This, of course, his employer did not know. One might say he was hysterical and suffered from a hysterical psychosis, a useful terminology but not in vogue today. On the other hand, it would be permissible to say that the defendant was suffering from reactive agitation or better, in this instance, mania. If the defendant had disappeared from the scene of the assault, continued in his excited state, and had been brought to some hospital where no inquiry could be made as to the events of the day, it is not improbable that there would be a tendency to diagnose the condition as the tweedledum or tweedledee of manic-depressive psychosis or schizophrenia, sub-acute alcoholism.

The term reactive depression has assumed a respectable place in psychiatric terminology, whereas its obvious correlate, reactive agitation or mania has no place whatsoever. Is there no such condition or are there reasons why it is not recognized or acceptable? A common sequel of depression is a suicidal attempt. The patient risks his own life. The law is not too concerned about suicide, except in the matter of insurance. A common sequel of mania is assault or even homicide. With this more grisly deed the law is closely concerned. However,

one would not ordinarily assume that fear, a sense of justice, or morality would influence the psychiatrist, whereas it might influence the judge. It is easily observable in daily life that a person has more celerity to assault when provoked, than to attempt suicide. Reactive mania therefore should hold a more distinguished place than reactive depression. The legalistic mind would not so readily accept the view of reactive mania as it would that of reactive depression for obvious reasons Why, however, would the psychiatrist not recognize such a condition?

At this point it is discreet to drop our hypothetical defendant and turn to an actual patient. A woman is brought to a hospital by her husband. He states that she is highly disturbed, has not been sleeping well for some time, talks at him continuously, has threatened him and has actually scratched his face. At times she broods. Life with her is intolerable. The condition has been developing for several months and has gradually become worse. She even has been in a mental hospital before. He is quite willing to pay her bills. The husband seems tense, obviously distracted by his wife's illness. He gives the story in orderly and consistent form. He departs after half an hour and his wife is left in the custody of the hospital. In accepting the patient the hospital has accepted the husband as a responsible person. The fact that the husband is wise enough to bring the patient to the hospital would show, one might say, that he had a sense of responsibility and concern. The wife, at the moment, obviously is more agitated than the husband and hence she is ill. On the other hand, one would like to know the husband's reaction immediately upon leaving the hospital. Did he have to drown himself in liquor. Could he have controlled himself, and perhaps his violence another hour or two? Did he really protect his wife by getting her away from himself and possibly violence? Would this little thread really indicate who was more ill? Perhaps, and perhaps it is the only thread after all; the problem requires much more study. If the wife really is not ill, the hospital might be in a pretty predicament If the hospital authorities dislike or fear scandal they will attempt to protect themselves from such situations. Their actions might not be deliberate but unconsciously motivated. An easy way is to label the patient as psychotic. After a few weeks, who will be able to say what her condition was on admission? This action may be based on fear and on a failure to make a proper investigation. The same might hold true in practice when a physician might be flattered or have a pabulous interest when a patent is brought to him; these failings, too, may be just

human and not malicious. The diagnosis of psychosis also is a safe one as far as any possible suicide or assaultiveness is concerned; very much as it is the safest thing to take out the appendix if the patient has a 'tummy ache'. The operation irrevocably establishes the diagnosis.

The patient then has been tagged manic-depressive psychosis. To psychiatrists, mental or emotional diseases are, or should be like other diseases, generally curable and without stigma. They should not, in the psychiatrist's eye or care, damage an individual socially or mentally. Apart from psychiatrists and a small body of other individuals, this of course is not the present state of affairs; to have been labelled psychotic really is damaging and to some individuals a crack of doom. Hence the need for the greatest solicitude and care in arriving at such a diagnosis.

The patient we are discussing has a relative who always felt the patient was a personable being who always got along well with her and this relative was amazed to learn that the patient had been pronounced psychotic (also prejudiced in her way). She visited the hospital and felt that her beliefs were confirmed. Although agitated, the patient was very much her old self. The facts obtained were that she and her husband had not been getting along well for a considerable time. There were disquieting disagreements about ways of sexuality and ways of living (Boston versus Texas). The patient was a homebody concerned about her home and children. The husband was more colorful and liked a gay and active life. He stayed out till all hours of the night, came home drunk and beat her up. At times she fought back and talked as loudly as he did in defending herself, and on an occasion bruised his leg while kicking him in a scuffle. She resorted to no alcohol in quieting her tension but occasionally took a sedative when overwrought. She was quite afraid of her husband and did not know how to react to his statement when he called her 'crazy'. She called him 'drunkard'. In any number of such instances she could have taken him to a hospital and the situation would have been reversed. However, she never did this because of a sense of loyalty. The trip to the hospital agitated her more and calmed the husband and for obvious reasons. It becomes clear that the reason why the wife and not the husband ended up in the hospital was not because she was agitated (they both were), but because the husband finally felt the situation to be more intolerable; he had less stamina, acted outwardly more so than his wife, and was a little less loyal.

What hospitalization fortunately did was to separate these two individuals. What it should not have done was to penalize the one individual so much more than the other. Why these two individuals could not separate more amicably much before this is interesting but a separate story that does not have immediate bearing on the subject as here presented. They both were living out conflicts. They both were sane or they both were insane. The first accuser momentarily placed the other in a hazardous position. A fortuitous intervention saved the day.

In such instances, the psychiatrist who receives a patient cannot be too cautious lest he make a prejudicial diagnosis. The patient must be reassured that she faces no danger, that she may speak freely and in confidence, and that she has certain rights. Indeed, it is a highly delicate point whether a patient who has enough sanity, in a word, to place confidence in the physician, should subsequently be declared insane on the material so submitted. If insufficient caution is used it may in time be necessary to inform each patient that what he says may be held against him. Indeed the psychiatrist must be a dual counsel, where both sides are heard impartially and where each side knows how much information the other side has yielded so that there will be no one-sided loyalty and no one-sided calumny. It may take months to establish a correct diagnosis. In the above instance the diagnosis would have been reactive agitation, certainly not psychosis. The diagnosis in the case of the husband might have been reactive agitation, alcoholc tendencies. In time to come only attending psychiatrists who see the patient outside of the hospital will be able to arrange for admission to a psychiatric ward or hospital, except in rare emergencies, very much as in the other fields of medicine.

If, in this case, prior to hospitalization, psychoanalysis had been suggested as a therapy and the patient was not given sufficient reassurance to speak about the immediate situation and her husband, this real situation might be cut through in following the regredient thread of the libido into childhood and infancy. The transference situation might become pleasant to the wife. She might feel the analyst to be her protector, while the husband's behavior might improve when he erroneously thought that his wife was speaking about him each day. Actually he might be mentioned very little after the first few days of analysis. The analyst might believe he had effected some sort of cure after the wife subsequently made the bleak decision to give up her husband, without revealing that she dreaded to return to the original, real, and unravelled situation (loyalty again). Or she might conclude her treatment and have

the condition recur when the husband became truculent again. Her revelation would depend not on how much she admired the analyst's intelligence, but in how much she felt he was capable and willing in real action against the husband. Certainly, her parents being dead, to whom could she turn? She might not be wise enough to engage counsel. If she left her husband, he would be enraged at the supposed perfidy of the analyst. The analysis would have achieved more justice than therapy, which justice could have been achieved less tediously and less expensively at once by legal means. The analyst might decide finally that the husband, by showing his rage, was ill and needed analysis, although he had been so wise and well in suggesting originally that his wife was the sufferer. Hence the greatest discernment is required in discovering the nature of the real and immediate situation, as well as in making a bald decision to inquire into childhood conflicts. The cure must not be worse than the disease. Today the tendency remains to forget the immediate situation and to seek the lump of solution at deeper levels. Often, however, it is not one childhood but the clashing of two childhoods that is the root of the trouble. This should be recognized immediately and not after two or three years.

It may be that these consideratons could only apply in a society where power, force, and first accusation were not supreme. It may be that this social state will never so radically change. None the less, it is obvious that one cannot truly be a psychiatrist if one yields to power, force, and first accusation rather than to truth, reason, and the scientific method. The application of a measure of common sense would be acceptable if it were not to include prominently, the well-being, prestige, and purse of the psychiatrist.

In another instance where the husband brought a similar patient to see me, I suggested that both husband and wife immediately begin to gain understanding under separate psychiatrists. However, the husband was adamant in his view that he did not have to drink or beat his wife if she altered her behavior. Needless to say, he was incorrect and suffered accordingly. Yet, later, he was not prejudiced against the psychiatric approach upon seeing his error, for he felt that he had been correctly advised at first. It is wise to keep in mind that one must watch for elaboration and falsehood from both sides; without a dispassionate view, the false may seem more true than the real. Numerous individuals do have a prejudice because they were not correctly and fully advised in the beginning. Hence the importance of descrying all facts in the

immediate real situation, the salient element of two childhoods opposed to each other and not one as the sole cause, and the urgency of doing all of these at the *beginning*. Therein lies the significance of appreciating and properly appraising, where it exists, the condition that here is called reactive agitation, or in its more intense form, reactive mania. Where homicide is the sequel, the picture may assume what has been called 'the crime of passion.' Passion it may be, but often *á deux*. Reactice agitation is not a rare condition but rather common and erroneously diagnosed as manic depressive psychosis, paranoia, or hysteria. Only failure to examine, question, and observe carefully can lead to such errors. In psychiatry as in surgery there rarely is need for hasty technique. The careful, patient, searching, detached psychiatrist will not be caught in such snares.

25 West 54th St.
New York, N. Y.

THE FAMILY, NEUROSIS AND CRIMINOSIS

I. ATKIN, M. D., D. P. M.

London, England

I

Similar Etiologies of Neurosis and Criminosis

Psychologists have often pointed out various affinities between neurosis and criminosis, this aspect being particularly stressed by Stekel. Certainly there are many causal factors common to each group, and nearly all the problems of criminality mentioned by Katzoff (1943) could equally well be raised with reference to the neuroses. I will only note such parallel problems as (1) The relative powers of genetic, environmental and cultural factors. (2) The influence of unemployment and occupational maladjustment. (3) The mode of child training. (4) The influence of neurotic parents. (5) To what extent analysis can prevent or cure neurosis.

Why under very similar circumstances one person becomes a neurotic and another a criminal, is a problem still in need of elucidation. It would appear that the antisocial tendencies can take the form of various symptoms, including phantasies and obsessional thoughts, in the neurotic; whereas the criminal acts out the trends on the plane of reality. It may be that there is some underlying constitutional pre-disposition to account for the difference. From the psychological point of view I would suggest that it depends on which side the essentially "active-passive" nature of the individual leans. The aggressive tendencies following frustration are directed more inwards in the neurotic, more outwards in the criminal. It is also possible that examples from the patterns of behaviour in the environment are imitated in some cases of delinquency. Healy and Bronner (1936) give three instances of varying influences in different national communities: how truancy is rare in Switzerland, the frequency of homicidal behaviour in Finland where fighting with knives is traditional, and the very common occurrence of "hold-ups" in America. However it be, the removal of etiological factors common to the group would diminish the incidence of both neurosis and criminosis.

II

The Vicious Circle

In the course of my examination of many hundreds of cases of neurosis, I was impressed with the frequency of a patient remarking that he has suffered from some symptom or other "on and off as long as I can remember." When the symptoms were of comparatively recent duration, the patient would very often give a history suggesting that he had not been healthy for a very long period. Typical examples of phrases actually expressed are: "trouble dates from the age of 11," "depressions since the age of 14," "always been nervy," "never been really well," "never known what it is to have sound nerves," "always inclined to be nervous, never a good mixer," "always a nervous type, since a child." And where not as much as this is admitted, subsequent investigation almost invariably revealed that unhealthy attitudes and reaction trends had been fostered in the distant past. It soon became clear that unsatisfactory types of behaviour had been conditioned in a family setting during childhood, and had become with repetition more or less rigidly fixed as habits thereafter. To analyse and synthesise such unhealthy patterns, in other words to decondition the patient into healthier attitudes and forms of behaviour, is indeed a herculean task to undertake in the patient's later cycles of life. Even if deep analysis could be successful for the majority of neurotics, nothing less than a vast army of psychiatrists would be required for this purpose. The situation has indeed reached a crisis in war time when many cases of neurosis occurring in the services have to be dealt with quickly in an adequate manner. The very length of an orthodox analysis, perhaps two years or longer, makes such treatment an impracticable course of action. Once again we are forcibly impressed that prevention is not only better than cure, but also a far easier measure in practice. The immediate urgent necessity would appear to be an increase in the number of Child Guidance Clinics where the trouble could be attacked in its earliest stages. But here we soon find that we are faced with a kind of vicious circle, for in child guidance work we again strike the problem of neurosis – latent, mild or severe – in the adult, namely in one or both parents. We discover that the child is being wrongly conditioned because of an unsatisfactory family environment, including all grades from a mild disharmony to the varying atmospheres of neuroses and the most extreme cases of broken homes. With regard to the parallel situation of crimin-

ality, my personal experience is limited to the study of cases of juvenile delinquency, but I believe the above principles to be equally true in their general aspect for the evolution of the adult criminal. In support I would quote Bonger (1936): "The overwhelming majority of adult criminals began their career, or were already demoralised, while still young . . . The accumulated material which proves that bad example, neglect, are very important factors in causing criminality, is simply overwhelming."

III

The Family Situation

The social causes of the present family situation, and the effects on parents and children, include a vast field for discussion; only the more outstanding aspects will be dissected here.

The ultimate determining factors of an unsatisfactory family life are found to lie in frustrations of the occupational, recreational, love and social trends of the individual. In almost every neurotic patient there are complaints referable to one or more of these items. Feelings of loneliness, lack of social contacts, absence of recreations and artistic interests, complaints of vocational maladjustment, inadequacy of the love situation, are noted again and agan during the analyss of cases of neurosis.

The causes of occupational frustrations can be classfied under: (1) lack of opportunity to adopt the vocation desired because of poor family finances (2) where an unsuitable vocation is forced upon a child by the parents (3) unsatisfactory conditions of work, including inadequate remuneration (4) unemployment and fear of loss of employment. The immediate reactions may be despondency, gloom and depression, or irritability, annoyance and outbursts of temper. At best such a frustrated individual will be disgruntled and unhappy, harbouring a grudge against society. A patient of mine who found his work "soul-destroying and non-creative," became more and more irritable, snapped at his wife and children, felt restless and bored. There is a tendency to use the wife and children as scapegoats for all the husband's dissatisfactions. Compensations may be sought by belittling the spouse, "taking it out" of other members of the family, playing upon their inferiorities (real or imagined). The children may be so severely bullied as to grow up with a sense of inferiority.

Another type of father may try to project his unattained ambitions onto his children and live out his life in them. He may force a child into an occupation totally unsuited to its capacities and desires, thus determining the development of conflicts, neurosis or even delinquencies. Under any circumstances such a child will grow up to be a dissatisfied misfit in the occupational world.

Yet another type of reaction to frustration in the father is to seriously repress the liberty of the children, or even indulge in corporal punishment. The child's trends for adventure and variety of experience may be restricted on the specious ground that he or she may fall in with evil companions, learn bad language or develop undesirable habits,—with a resulting lack of proper social development; the more unfortunate ones will seek an escape in neurotic phantasies or delinquent behaviour. Corporal punishment is often justified with such threadbare platitudes as "spare the rod and spoil the child" or "it did me good," and the whackings are accompanied with the hypocritical phrase (the evident untruthfulness of which is obvious to the real sufferer) of "it hurts me more than you." That such victims grow up to be sneaky and timid, or callous and spiteful is not at all surprising.

In the wife the effects of lack of adequate occupation may not be experienced until the children are fairly grown up, but in the forties, when these not longer require much of her time, she is apt to feel bored and will attempt to cling to them, thus retarding their independent development. This, indeed, may happen in earlier years where the love life of the parents is unsatisfactory. In these cases the mother turns to the son, the father to the daughter for the affection which they have missed in each other; mother-attached sons and father-attached daughters are the fruits, often enough to repeat the same cycle in the next generation. These children run the great risk of being spoiled, pampered and overprotected, which actually also amounts to frustration of their liberties from another point of view. This may of course happen under other conditions, e.g. where there is an only child, or where parents lack wider social interests. The harmful effects in the offspring are many and varied, – lack of independence, impaired social development, hypochondriacal tendencies, formation of timid personalities, etc. The results of a research at the Institute of Child Guidance of New York on maternal overprotection have been recently given by D. M. Levy (1943). Amongst the undesirable effects on the child are noted: tantrums, excessive demands, lack of interest in sport, difficulty in making friends. Parental sexual maladjustment and a lack of common interests

in their social lives were frequently found to be present. Many of the mothers had themselves experienced unsatisfactory parental relationships when children. Treatment recommended includes: psychotherapy of the mother and father; widening of the interests of the mother to bring her into closer social relationship with her husband; arrangements of social contacts and activities outside the home for the child. It is admitted that therapy is difficult and takes up much time. The importance of family disharmony etiologically, and the necessity of wider social orientations for parents and children are thus brought out in this investigation.

Although there is a prevalent wishful belief that woman has at last realised a social status equal to that of man, in actual fact she has neither economic nor professional equality. Apart from man's fear of increased competition, he wishes, by keeping women in subjection, to maintain a convenient object for the working out of his frustrations and inferiorities. With this prevailing tradition, daughters are at a disadvantage from the first as compared with sons. Often have I heard complaints that everything was concentrated on the "son and heir," whilst no career was planned and less freedom afforded to the daughters. Many girls grow up with a sense of bitterness in this respect, and when they marry, their husbands are destined to be rewarded with frigidity as a form of revenge against man's repressions of woman's social ambitions in life.

The far-reaching effects of very poor financial situations on family life, – residence in slums, overcrowding and lack of privacy, malnutrition, bad sanitary standards, lack of recreational and cultural facilities, low level of all the material comforts of life, – with all the attendant frustrations and humiliations on parents and children, are too well known to need detailed treatment. Here I wish to draw particular attention to the deleterious influence of economic factors on family love life, not only in the poorer sections of society, but also in the middle classes. The wife, in spite of contraceptive appliances (often unreliable owing to ignorance) may be so dreading the economic difficulties of rearing another child that her anxiety inhibits all pleasures of intercourse. In some cases, owing to a persisting traditional belief that an absence of climax will prevent conception, the wife deliberately avoids self-abandonment during coition. Apart from such ruination of sex relations, which I have frequently discovered in neurotic patients, it may be said in general that until woman becomes a useful worker in society and acquires economic independence, love, even when present, is inevitably perverted by conscious or unconscious economic motives. At present

it must be admitted that there is much truth in the oft repeated cynical statements that "for women marriage is at best an economic investment, at worst a form of human slavery." The misfortune is that many women stumble through life, discontented and unhappy, quite unaware of this essential fault which so often disturbs the harmony of family life.

The general *Weltanschauung* of the adult, and its inevitable repercussions on children, depends considerably on the birth rate gradient. In a society where the latter is falling, and the population becoming more and more elderly, there cannot be that desire of working not only for oneself but for a better world in which a large rising generation will enjoy more and more the fruits of life. A growing atmosphere of senility begins to permeate every aspect of life, marked by pessimism and cynicism. Here also we have a vicious circle: economic frustrations of youth↗declining birth rate↗older people dominating social institutions↗less i nterest in improving the conditions of youth↗economic frustrations of youth. R. & K. Titmuss (1942) in their study of the declining birth rate in acquisitive societies demonstrate that the relentless fall in births during the past 60 years in Britain, U. S. A. and many other countries is not an obscure biological phenomenon but a deliberate reaction on the part of parents to the difficulties of their own lives and that of their children in an exploitative economic system, – that it is an expression of mankind's urge for new social values.

Because of the lack of adequate educational and cultural facilities, many members of society are unable to utilise such leisure as they have in enjoying really worth while recreational and social activities. As a consequence, family life revolves in a very narrow circle, with the inevitable concentration on petty items and the outcropping of squabbles over the minor aspects of life, – all a fertile soil for the development of neuroses in both parents and children.

The disastrous effect of many of the above mentioned factors on the family situation in the American middle and upper classes has been well presented by D. Cohn. Much of the wife's unhappiness, boredom and discontentedness is due to the fact that she has not been given opportunities for a full development of her personality. The result is that instead of being a sympathetic intimate companion of her husband, she is more in the nature of an amusing piece of furniture. Of course the sex relationship is also unsatisfactory, and the children suffer in consequence.

Marital disharmony is very frequently based on lack of love between the parents, though the real trouble may be overlaid by various

differences of opinion and quarrels concerning apparently unrelated subjects. The principal causes of heterosexual maladjustments can be broadly classified under: (1)Where the partners were admittedly not in love from the commencement, and had married through parental pressure, to escape an unpleasant home or on distinctly monetary grounds (2) Where the marriage is based on mere physical attraction and a simple desire to satisfy physiological trends, there being a total absence of common spiritual interests (3) Where there is mental sympathy, but one or both partners are imbued with wrong views on the physiology of sex. In the first and third groups, varying grades of frigidity will almost certainly exist from the very beginning; in the second, this may well develop later in married life. This symptom is expressed as a complaint with monotonous frequency by female neurotic patients or their husbands.

The economic, occupational and social difficulties which are obstacles to a succesful love situation have already been discussed. With regard to ignorance or misinformation concerning sex functions, the state of affairs is no better. Although there is a popular belief that we are living in an age of "sex enlightment," in actual practice it is still rare to meet a really healthy attitude to sex even amongst normal people, let alone amongst neurotics. There are no widespread arrangements for acquainting children and adolescents with the appropriate scientific facts, and our young generation grow up with many bizarre and superstitious ideas concerning sex. Parents are either too ignorant, or unwilling because of their own conflicts, to perform this task of education, and schools still tend to brush this subject away very hastily. Adolescents are driven to gather their knowledge from improper innuendos in magazines, doubtful jokes on the radio, *doubles entendres* from the music hall stage, and come to associate sex with something indecent or sinful. Curran, Strauss and Vogel (1943), in their usefully therapeutic sex conferences, have collected much evidence exhibiting the prevalence of misinformation concerning even the simple facts of sex life. They point out the harmful effects on the individual, e.g. the development of guilt neuroses. Stekel, in his book "Frigidity in Women" (1926) stresses the importance of social factors in determining the rapidly mounting frequency of this symptom in these words: "Unfortunately the mental and emotional peculiarities which I have described in connection with woman's love life are typical manifestations of our age; their strength, no less than their forms of expression, is deeply rooted in our social forces and the aberrations of woman's love life can be explained only through

these social forces," He also points out that only the establishment of absolutely equal political, economical, educational and social rights for woman can create conditions under which she will be enabled to love in a healthy, untrammelled manner.

Much of what has been said above concerning the inadequacies of family life is so prevalent that pessimistic sociologists and psychologists have come to accept the position resignedly, and what is really "pathological" is accepted as "normal." We must now allude to the more extreme cases where the parents are already gangsters, drunkards or prostitutes. It need hardly be stressed that children brought up in such family environments almost invariably follow the pattern set before them. It is the parents who first prepare the child for socialisation, and if their lives are marked by loose standards, the children will readily be infected by the atmosphere of immoral codes. J. F. Henderson and A. N. Norris (1938) quote a series of 150 delinquent boys of whom 55% had suffered from broken homes (illegitimacy, step-parents, unfaithfulness or drunkenness of parents, etc.) These of course are only the grossest cases of marital disharmony in the series, and it does not follow that the home conditions of the other 45% were at all adequate. G. W. Henry and A. A. Gross (1940) in a review of social factors in delinquency mention that out of 200 youthful delinquents examined, only 2 came from homes that could be called comfortable. They also stress the noted frequency of broken homes in studies of offenders.

According to Kanner (1935), a "harmonious family life is one of the best guarantees for the smooth adjustment of a normal child and for the optimal adjustment of one handicapped," and he observes that in the vast majority of cases of behaviour disorders in childhood, domestic frictions are present. Parents who are fortunate enough to be well adjusted to each other as well as socially and occupationally, do not find it necessary to nag, spoil or ill-treat their children, do not need to indulge in favoritism or relieve frustrations by instilling fears and threats in them, or vent irritations with outbursts of temper and corporal punishment.

In further confirmation of the importance of the etiological factors that have been emphasised as causative of behaviour disorders in children, I will quote, in contrast, some findings from a study of a group of well adjusted children by D. A. Thom and F. S. Johnston (1939). Of the parents of these, nearly 80% had happy childhoods; as a group they were well educated; the majority fell within the higher levels of the occupational scale; there were relatively few unhappy marriages; both

parents enjoyed a variety of interests outside the home; there were but few marked personality deviations. Of the children, over 80% had been well socialised and had many friends of their own age; they have been encouraged by their parents to take part in group activities and had been free to invite friends to their homes; in but few cases were instances of favoritism noted.

IV

Centre of the Vicious Circle

To cure neurosis and criminosis, involving as it does the treatment of many thousands of adult patients and the parents of child patients, is a task too vast to be adequately performed by the number of physicians that could ever be rendered available. Something of the difficulties in treating neurosis in both adults and children has already been touched upon, but juvenile delinquency offers perhaps an even greater task in the amount of time to be spent by physicians and social workers and in the variety of social services that have to be rendered. Healy and Bronner's very full programme included such items as: medical, economic, educational, social aids for the parents; country vacations; excursions to develop hobbies and new interests; months of special tutoring; various recreational arrangements; parties at the clinic; clothes for those in poor circumstances; piano and tap dancing lessons. Whilst all this is feasible in some centre where a large staff and ample funds are available, it is obviously not possible on a nation-wide scale where we have to depend on charitable bequests and voluntary help. If, however, the state arranged for adequate educational, medical, recreational and economic conditions to exist as a normal feature of the social organisation, the root of the evil would be cut at its source. Healy and Bronner raise the crucial question: "Shall we be forced to the conclusion that with existing social, economic, industrial and recreational conditions . . . families cannot be expected effectively to alter situations that are fundamental in forming antisocial conduct tendencies?" The answer for the nation as a whole under present circumstances is in the affirmative, for the good results obtained by these workers were possible just because they were able to improve the social conditions for the group studied.

Undoubtedly a great increase in the number of satisfactory family situations would result in an enormous diminution of both neurosis and criminosis. It has been traditional to repeat that a society cannot be sound unless it is founded upon the pillars of healthy family lives, but are we not committing the very common error of placing the cart before the horse? If we take an extreme case, the very low ebb of family life

in decadent Rome, what faults do we find in the social organisation of that period? Here are a few striking items of social life in Imperial Rome from Stadelmann's account: a mad pursuit of wealth has become Rome's ideal; slavery was accepted as an essential necessity for society; side by side with incredible luxury and splendour, existed poverty and distress; many unemployed lived in utter destitution; an international company of rogues flourished in Rome; loose living was rampant in all the higher circles; political life was replete with intrigues, slanders, forgery, embezzlement, treachery, all sorts of corruption. Can we doubt that the low standard of family life in Rome was a necessary resultant of the very bad politico-economic organisation? We certainly have not reached such a low level, but historical warnings are worthy of attention. The indications for an improvement of the family situation surely lie in a modification of our present social organisation.

V

Preventative Therapeutics

We have seen how the seeds of neurosis and criminosis are sown early in unhealthy family situations, and that the latter are very considerably caused by various frustrations inherent in our present social structure. The social determinants are the factors to be attacked by our protagonists of social medicine. The following essential measures are here suggested:

(1) Full opportunity for every citizen, whatever his economic status, to take up a vocation in accordance with his talents and intelligence. Adequate remuneration in employment, disease and old age.

(2) Woman to have an equal status economically and professionally. Marriage no bar to any career.

(3) Widespread facilities for increased social and cultural life. Clubs, play centres, travelling theatres for rural areas, special theatres for children.

(4) Suppression of dishonesties and exploitations in business, law and politics.

(5) A fundamental alteration in our sense of human values. Esteem to be stressed for the social usefulness and cultural level of the individual rather than his annual dollar or sterling income.

All this may sound a vast and ambitious programme, but it is doubtful whether it would cost more than the total of our neurotic and criminal bills; and unless something in the nature of these measures is implemented, there appears no hope of any very significant diminution in the incidence of neurosis and criminosis.

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PROJECTIVE TECHNIQUES AS A PSYCHOLOGICAL TOOL IN DIAGNOSIS*

ISABELLE V. KENDIG

Chief Psychologist, St. Elizabeths Hospital
Washington, D. C.

Some years ago I sat in on a symposium at the Harvard Psychological Clinic at which were presented the findings on a group of subjects who had taken the Thematic Apperception Test. In the discussion that followed, a well-known analyst declared most generously in reference to one case, "You have dscovered in two sessions what it would have taken me 200 analytic hours to obtain."

At this time, when we are finding that 50% of the medical casualties in the present conflict are neuro-psychiatric cases, any methods offering a shorter approach to diagnosis and therapy are deserving of careful examination and appraisal. It is for this reason that I propose to discuss this afternoon two projective techniques which we are using increasingly at St. Elizabeths Hospital with fruitful results. One is the Thematic Apperception Test developed by Murray[1] at Harvard within the past 10 years, the other, the better known Rorschach Test.

All projective techniques, and there are many others (e.g. the Musical Reveries Test and the Dramatic Productions Test), are designed to uncover inhibited and repressed tendencies by stimulating imaginative processes and by facilitating their expression in words or action. The material presented – the ink blots, pictures, music – is purposely neutral, ambiguous, or incomplete so that the interpretations elicited are in terms of the subject's dynamisms. His attention is diverted from his own psychic processes, and almost always, if naive, he feels that he is talking about the objective presentation, not about himself, and therefore is off guard and ceases to be defensive.

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The Rorschach, or ink blot test was devised by a Swiss psychiatrist, Dr. Hermann Rorschach, and first published in 1921. It is one of the oldest and certainly the best standardized and most widely used of all the projective tools we have. A great deal of critical work which it has inspired has largely validated the primary Rorschach principles of personality diagnosis both in healthy and diseased states. The test has been found useful not only in mental hospitals and private psychiatric practice but also in schools and colleges, in industry, and in the armed services as a means of evaluating the capacity for adjustment, weeding out the neurotics and incipient psychotics, and picking leaders. To facilitate its more general use a method of group administration has been developed and more recently still it has been thrown into the form of a multiple choice test.

It is impossible here to discuss the Rorschach in detail and the many factors which may be analyzed out from the series of interpretations obtained to the 10 blots. In general, however, it should be emphasized that no one sign has any fixed value. It is the total pattern (or 'Gestalt') which emerges that counts and these patterns are as individualized and significant as our faces – all composed of the same essential features yet each different. But whereas character can be only imperfectly surmised from appearance, from these psychograms, as Rorschach frequently called them, it is possible to gain a remarkably accurate understanding of basic personality structure and modes of reaction. While the test may be used to assess the various aspects of intelligence, its most original contribution is to our understanding of personality.

It is to Jung we owe the concepts of introversion and extraversion—concepts usually greatly over-worked and very loosely applied. Innumerable personality inventories have been devised to evaluate these traits but they deal only with peripheral manifestations. Rorschach has boldly grasped the problem, defined the essential nature of introversion and extraversion, and built thereon a brilliant theory of personality which, better than any other yet developed, meets the pragmatic test—it seems to work and to have predictive value.

Rorschach makes it clear that his use of the terms introversion and extraversion is much closer to the popular than to Jung's. He discovered empirically two primary reaction types – or as his term 'Erlebnistypus' is commonly translated: Experience types. On the one hand are those subjects who project movement into the blots (the M type), on the other, those whose interpretations are more influenced by color (the C type). Those in whom kinaesthesias predominate, he found, show

more individualized intelligence, greater creative ability, more "inner" life, stable affective reactions, less adaptability, more intensive than extensive rapport, measured, stable motility, awkwardness and clumsiness – in short approximate the accepted conception of the introvert. Subjects, on the other hand, who are predominantly responsive to color show more stereotyped intelligence, more reproductive ability, more "outward" life, labile affective reactions, more adaptability, more extensive than intensive rapport, restless, labile motility, skill and adroitness – in short are fairly close to the popular idea of the extravert. An intermediate type characterized by a balance between M and C expression is known by the less familiar term ambivert. Perception, imagery types, intelligence and talents, he found, all reflect these underlying differences in reaction.

The use of the Rorschach as a diagnostic tool also derives from this fundamental trichotomy. Although the presence of mental disease may in some cases cause a shift in the experience type, in general it has been found that these basic differences in personality structure are the predisposing factors in the type of psychoneurosis or functional psychosis that may ensue. Thus, any individual may develop an anxiety neurosis but in introverts it tends to take the form of neurasthenia or psychasthenia; in extraverts, of hysteria. The nearer the type approaches the ambi-equal, the more certain it is that what has been simply fear becomes compulsive anxiety. Ambiverts with more introversive traits display more obsessional features, those in whom extraversive traits predominate somewhat show compulsive activity.

At the level of psychosis, it has been found that in manic-depressive states the experience type also tends to be ambi-equal but with extreme constriction both of movement and color in depression and great dilation of both in manic conditions. Since true ambiversion in normals is relatively rare it may be that here the disease is responsible for forcing the personality type toward the middle. A clinical relationship between manic-depressive insanity and obsessive-compulsive neuroses has frequently been noted and it is interesting that in this diagnostic schema both fit into this middle group.

In schizophrenia, dementia simplex is associated with complete constriction of the personality, neither movement nor color being responded to; in catatonia, the personality is also ambi-equal but dilated; in paranoid states, introverted; and in hebephrenia, extraverted. While it seems probable that schizophrenic catastrophies, especially sudden catatonic attacks, cause shifts in the experience type they do not change it from

its normal expression sufficiently to make this change the essential determiner of the form of psychosis. It is more probable that those who were originally introversive become paranoid, those who were extraversive become hebephrenic and those who were nearer the middle become catatonic. Perhaps with increasing understanding of the shifts in experience type in the course of normal life there will be a clarification of the whole problem of schizophrenic types in relation to age.

In epilepsy, there is a constant widening of the experience type in both directions as dementia progresses but throughout its course extraversive factors predominate and the color responses seem almost to constitute a measure of the deterioration.

In contrast to these various conditions where the experience type exerts a determining influence on the form of psychosis or neurosis, it has been found that organic pathology definitely changes the original experience type. Except in Korsakoff's psychosis, introversive factors decrease and extraversive factors, representing egocentric affect and emotional instability, increase rapidly.

While there are many other Rorschach factors to be taken account of before a diagnosis can be made, – especially the approach to the task, the accuracy of the form perception, the recognition of the more popular figures in the blots, the degree and kind of stereotypy, and the various signs of anxiety or neurotic shock reaction –, the final determination of the type of neurosis or psychosis rests primarily upon a study of the balance between the introversive and extraversive forces in the personality as reflected in the M and C responses. This is Rorschach's unique contribution – as important in the field of psychiatric diagnosis as in the study and understanding of normal personality patterns.

There is one other aspect of the Rorschach, however, which should be considered and that is the *content* of the interpretations. Primarily, as has been pointed out, the test reveals the structure of the personality and Rorschach himself tends to minimize the significance of the content elicited. Nevertheless, he does recognize that certain responses are "complex indicators" such as Jung and Riklin found in their association experiments. Frequently patients offer interpretations which clearly reveal their underlying tensions and conflicts. Sometimes these are already obvious but often they disclose repressed and unsuspected difficulties and thus offer new therapeutic approaches.

For example, at the present time, we have in the Hospital a Marine Corps captain who was wounded in action in the South Pacific when a demolition blast occurred near him in which a number of his men

were killed and after which he developed mental symptoms. He narrated his story to the examiner with great circumstantiality displaying a grandiose attitude and marked paranoid projections. At its conclusion he had an attack resembling a petit mal seizure from which he emerged with complete amnesia for all that had passed in the interview. The Rorschach instructions had to be repeated as though de novo. After considerable delay he interpreted the first blot as "a piece of shrapnel" then suffered another hysterical seizure and had to be returned to the ward. Such a response was undoubtedly a "complex indicator."

A colored seaman recently admitted to the Hospital, and transferred to Howard Hall because of his attempts to elope and his destructive and assaultive behavior, gave a long series of Rorschach interpretations revealing explosive affect. His only color interpretation was of blood which, like fire responses, is almost always indicative of marked emotional instability. In addition, he gave a number of curious interpretations of movement in inanimate nature all concerned with violent and disruptive forces. Thus, in one plate, he saw "a man blown to pieces by a bomb"; in another, a person who has been "wrecked – his arms all broke and drooping"; again "a piece of a person – his stomach blowed open." During the inquiry period he elaborated on one response, in which he had described the midline as a spinal column, by adding that "his stomach is blown open." While these responses all concerned human bodies (so-called anatomical answers) the same motif occurred also in one other object interpretation in which he perceived "the eagle on a staff sergeant's cap blowed to pieces." Such production, especially the high score for anatomy responses (59% of his answers belonged in this category with particular repetition of kidney responses) suggests that his frenzies are not true manic attacks (the Navy diagnosis) but represent an epileptic equivalent. Certainly his behavior since admission bears out the Rorschach findings that he is potentially very dangerous.

A very different type of production was given by a young Naval officer hospitalized because of perverse sexual behavior involving exhibitionism. A study of his content, especially the repetition of certain verbs and the choice of a few others, is very revealing and suggests ambivalence and great sexual conflict. Alternately he saw forms "tied" or "pressed together" and others "sticking out." Twice they are "tied", and once each "pressed together", "glued on", "broken", "wrapped". On the other hand, 4 times he describes things as "sticking out," twice as "stretching." The former replies are indicative of repression, the

latter of overt aggressive trends; together they point to a sado-masochistic component at the root of what is very evidently a severe anxiety neurosis characterized by obsessional sex fantasies and occasional outbursts of compulsive behavior.

Such examples could be multiplied many times but these are sufficient to show the significance of content in Rorschach protocols. Primarily, however, as has been stressed, the Rorschach contributes to our understanding of the structure of personality and the extent to which it predetermines the type of neurosis or psychosis which develops.

When there is opportunity to make a more complete and penetrating study of personality and to uncover the dynamics of behavior, the Rorschach is supplemented by the use of the Thematic Apperception Test. Instead of the neutral blots, this consists of a series of ambiguous pictures about which the subject is asked to tell stories invented on the spur of the moment.

Murray, who devised this test, sharply differentiates such fantastical thinking both from chaotic mental associations that have no theme, on the one hand, and from realistical thinking, on the other. An individual does many things in his imagination which he does not do in real life. Most of these purely imagnary or unrealized acts seem to be engendered by desires and needs very similar to those that impel deliberate action but they are denied external expression (inhibited) because of the unpleasant consequences that might follow their objectification. This is true both of erotic and aggressive fantasies. Some fantasies, however, represent possible forms of *future* conduct, many are merely consolatory wish-fulfillments. Since the thinking of primitives, of children, of humorists, artists, religionists, and imaginative geniuses is, to a great extent, fantastical and the thinking which occurs in dreams and psychotic states is almost wholly so, Murray points out that the average civilized individual spends at least half a life-time (30 odd years) in fantasy, day-dreaming and night-dreaming. Its role then, although only imaginary behavior, can hardly be over-estimated.

Through an analysis of the fantasies elicited by the TAT, as the Thematic Apperception Test is now usually called, it is possible to determine the subject's basic drives or 'needs', his conception of the environmental 'press' which activates them, and the 'out-comes' he projects – in short, to uncover his so-called 'unity thema' or underlying reaction system. It is this which gives the key to his unique personality and enables us to fit individual responses and reactions, like pieces of a jig saw puzzle into a coherent and meaningful whole. Not only does

each of us have such an underlying unity-thema but research indicates that there are a limited and classifiable number of such themas. Those of you who remember the Leopold-Loeb case in Chicago some years ago may recall that a study of the two youths by a number of distinguished psychiatrists, including Dr. White, discovered that reciprocally they were dominated by a King-Slave fantasy. Other fairly easily detected central themas include the Cinderella thema, the Vampire thema, Rebirth thema, Orphan thema, etc.

There is time to present only suggestive illustrations of the type of thematic material which we obtain in the Hospital through the use of the TAT.

One of the simplest themas, but frequently controlling, is the Achievement thema. In this connection, I think of a man of 25 who has been in the hospital for four years with a diagnosis of catatonic dementia praecox which led to his discharge from the Army after 9 months service. His course here has been marked by alternations of recovery and relapse. During one of his remissions, he was given the TAT and he produced a series of fantasies that might well have been taken from Horatio Alger. Despite the fact that he has had but a 7th grade education and possesses only average intelligence, now somewhat blunted, he fantasies himself successively as a great orchestra leader, a Burbank, a great artist, an astronomer who discovers a new comet subsequently named for him, and a great lawyer. His unity thema may be formulated as p Lack ↗ n Achievement (compensatory) ↗ o Success. That is to say, we see a boy who feels himself deprived and robbed of opportunity by life, who suffers from feelings of inferiority and insecurity, and who compensates by fantasies of great achievement pathetically divorced from any reality he might accomplish.

As illustrative of the Guilt thema, there is the case of a patient now discharged who has had several manic attacks. His unity thema may be expressed as p Loss ↗ n Aggression ↗ o Guilt and Punishment.

The repetition of motif throughout the series of fantasies was so striking that even the patient commented upon it. For the same series of pictures that has elicited the Horatio Alger thema presented above, this patient's production may be epitomized as follows:

Plate III He has killed someone, his conscience hurts him, and he kills himself.

Plate IV He has done wrong and is imprisoned.

Plate VIII He has committed sexual irregularities and is very unhappy and needs help.

Plate X The evil man will be killed some day.

Plate XI The boy is worthless and will land in jail.

Plate XII He is a drunkard and will be jailed.

Plate XIII He committed murder and will be punished.

Plate XIV His victim dies and he will be punished.

Plate XVI The escaping criminal will be caught and put back in prison.

Plate XVII He has committed murder and is very unhappy; he will be caught.

Plate XVIII He has committed some crime.

At this juncture, the patient started up suddenly from his chair, turned to the examiner and said impulsively,

"Do you think I am a criminal – all these damn pictures you show me?"

Nevertheless, to the next two, which concluded the series, exactly the same type of projection occurred:

Plate XIX A Dracula. The man is hanged for his crime; he has suffered for what he has done.

Plate XX The man is sentenced for what he has done and may be sent to the electric chair.

A knowledge of this patient's life – the loss of his mother, his hostility to his father whom he feels imprisoned him here – helps us to understand these fantasies. They are significant in revealing the strength of his hostility and of his guilt therefor – a conflict which he has repressed but not resolved. In two of his tales, the outcome is suicide and unless his repression is successful this may seem to him his only escape.

In another instance, in which the wisdom of granting ground parole was in question, the Thematic Apperception Test was reassuring. This patient is a young Navy physician who had returned to this country from the South Pacific to study psychiatry. Shortly after undertaking the course he became nervous and apprehensive, began to believe he was suffering from the various mental maladies which he was studying, grew

more depressed and made a definite suicidal attempt. The series of fantasies which he produced here showed him to be a very passive, dependent, and deferential person, with great respect for authority (the Father-figure). There is a strong feminine component revealed by the fact that in four of his ten fantasies he identified himself with a feminine figure portrayed rather than with a masculine one. He conceived of his environment, in about half of the stories, as nurturing and protective but, in an equal number, as punishing and rejective. However, his incipient rebellion is always followed by guilt and atonement – a return to the ways that he has been taught. His guilt is probably considerable for in half of the tales he projects only a second-best ending and in one, salvation only by a fluke. From this material he appears still to be depressed but resigned rather than suicidal. He no longer entertains high hopes of achievement but will follow along content with mediocrity.

The last case which I shall present is that of a discharged patient – a young man of superior intelligence who appeared to be suffering from a severe anxiety hysteria. Of his 10 fantasies, 2 were so close to reality as to have obviously been drawn from conscious levels. For instance, he tells of a little boy who cut his finger while chopping wood, a task he was forbidden to do, but who is not punished by his mother. At the conclusion of this story he turned suddenly and held up his hand to the examiner and showed her a scar – thus admitting his identification with the hero of his tale. In another, he tells of divorce and a broken home and how none were happy thereafter, "especially the kids" – a description of his own early life. Two other fantasies may be eliminated from consideration because they are too much controlled by the stimulus to be revealing. One picture was rejected.

The remaining 5 fantasies deserve serious consideration, especially as regards outcome:

Plate II Because of his wife's infidelity the man jumps over a cliff.

Plate III Losing his wife, the man becomes a hermit and leads a useless life.

Plate IV He flies to the moon in a rocket ship which then explodes but he expected it and didn't care.

Plate V The central figure is jilted.

Plate X The man lives alone and is preyed upon by imaginary dangers.

An analysis of these fantasies forces the conclusion that the patient regards himself as deprived and injured by life, rejected by those who should have loved him. As a result he reacts with negative and rejective needs – to escape, seclude himself, and in return reject others. Almost all his outcomes are unhappy and represent either loneliness and rejection (the hermit life) or death (jumping over a cliff or being killed by a rocket ship). With such extremely morbid content, the possibility of ultimate suicide appears very real. How close he has already come to living out his fantasies is revealed in the circumstances leading to his hospitalization. After working his way through two years of college, under the stress of great financial difficulties, he became discouraged and drifted to Washington from the West Coast. He was found by the police living alone in complete destitution in a little shack on the Anacostia river, very literally the prey to "imaginary dangers."

In these examples, I have tried to indicate the highly individualized projections which exactly the same series of pictures elicits – Horatio Alger fantasies built upon the Achievement thema, aggression leading to guilt and punishment, passive acceptance of life and bitter rejection.

Using the Rorschach primarily as a tool for uncovering the structure of the personality and the specific mental diseases to which the various types are predisposed and using the TAT to disclose the underlying dynamics of behavior, these projective techniques offer significant leads not only to diagnosis but to prognosis and therapy as well. They serve to confirm and sharpen impressions gained from the psychiatric interview and frequently throw new light upon the nature of the basic conflict. Thus, as suggested by the Boston analyst, they may, in a few hours, yield material that the patient is unable to give directly and which it might require many months to secure through *free* associations.

AN UNCONSCIOUS DETERMINANT IN *NATIVE SON**

FREDERIC WERTHAM, M. D.

New York, N. Y.

Psychoanalytic studies of works of literature have often been undertaken. But the author of the work of literature was usually dead or unavailable. This has reduced such studies to the dangerous field of psychoanalysis without psychoanalysis. There is great temptation to speculate about the self-revelation of an author in the hero of his play or novel. Freud himself succumbed to such speculation in the case of Shakespeare.

If we want to arrive at valid conclusions about the psychology of literary creation, we must have access to the living author. As far as I know, no psychoanalytic study of a literary creation based on analytic study of its author has ever been undertaken.

What I shall present to you today is based upon one of the great novels of our time. We can recognize greatness in a work of art by the way its fame spreads over national boundaries. *Native Son* is popular in many countries. A leading Soviet critic, Yermilov, has compared Richard Wright to Dostoievski.

Wright is interested in psychopathological problems in relation to writing. He had to be deeply conscious of each step of progress he made as a writer and he wanted to know the uses of technical devices involved. Out of discussions we had on the relationship of psychiatry to literature, we decided to undertake an experiment to determine where certain elements in *Native Son* were derived from. Wright accounted for a certain element in this novel in a manner which was rational and fitted a political and social framework rather than a true emotional personal one.

There is an obvious advantage in working with an author for free associations to the symbols in his work. It is, in fact, the only scientific method for such a study. But there is also a grave disadvantage. One naturally does not feel free to reveal too much personal data about someone who is in the public eye. For this reason I am limiting what I present to you to a fragment which of necessity has to be severed from the context. While I was handicapped in my study of *Hamlet*[1] by the

fact that Shakespeare was dead, I am handicapped in writing openly about *Native Son* by the fact that Richard Wright is alive. This fragment, however, is enough to state and demonstrate certain definite conclusions about the psychology of the process of literary creation.

In 1938 Wright published an autobiograhical sketch "The Ethics of Living Jim Crow."[2] Recently he has written a much fuller account of his life: "Black Boy",[3] which is coming out this Fall. This autobiography is of considerable interest here. It has taught me one thing about autobiographies: they may be a literary disguise almost as hard to penetrate as a novel.

Wright himself attempted to interpret *Native Son* in a booklet he called "How Bigger Was Born."[4] Is this interpretation by the author himself correct? That is how one may formulate one aspect of my study.

That there is an identification between Bigger Thomas and his creator is evident. It becomes even more clear to anyone who reads *Native Son* and the autobiography, "Black Boy." How far this identification goes is a special problem in itself. It has always to be kept in mind that "a literary creation is not a translation but a transmutation of human experience" (Dark Legend).

Just as I believe that in *Hamlet* the key scene is the appearance of the father's ghost in the mother's bedroom, so the key scene in *Native Son* is when Bigger Thomas unintentionally kills Mary Dalton in the presence of her blind mother. (Bigger, as you will remember, is employed as a handyman in the house of the Dalton family.)

Had the author any knowledge or remembrance of a situation where a boy like Bigger worked in a white household, where there was a tense emotional atmosphere between the *dramatis personae?* Was he conscious of any fantasies or daydreams from which threads would lead to the key scene and its setting in the novel? The answer to both these questions is "No."

In the process of analysis a stage was reached where associative material, vague and fragmentary, was forthcoming, which was related to such scenes. But Wright did not know whether these scenes and figures were memories or fantasies. "Did I invent these people?"

The overcoming of resistance led to the emergence of more and more concrete and coherent situations. Fantasies became linked to living memories. It became evident to me that they had actually occurred in Wright's life. But even at this stage his sense of memory, if I may so call it, was still incomplete and lacked reality character. Fortunately,

through two relatives living near the places involved, the real existence of persons, names, and places could be checked. Speaking of one letter of verification he said, "I knew it and I didn't know it. It is strange when you see it black on white in front of you." Only some time after this were these experiences fully remembered and acknowledged by him. Then he said: "I am sure that this . . . was the soil out of which *Native Son* came. The moment it came I recognized it." These facts Wright had completely forgotten for eighteen years. In other words, the root experiences intimately related to the key scene of the novel were unavailable to his consciousness at the time of the novel and at the beginning of our experiment when he reflected on the sources of his inspiration for the creation of the Dalton household.

As an adolescent of fifteen, Wright went to public school and worked mornings and evenings for a white family. The lady of the house was young and pretty. She lived with her husband and her mother. Her real name was highly significant in the analysis and as a common English word had definite symbolic meaning. In his memory the figure of the mother is very unclear. She used to get the breakfast every morning. The daughter, the lady of the house, was friendly to young Richard and he felt this was a second home to him. She lent him money to make a down payment on a new suit for a special school function.

His chief duty was to tend the fireplace. He chopped wood and brought in the coal. I need not point out the definite relationship of these circumstances to those in *Native Son*. The fireplace corresponds of course to the furnace in the novel, in which the Dalton girl's body was burned.

Further associative material led to the recollection of a special scene. In the early morning young Richard would carry scuttles of coal and wood into the house. On one such morning when he was carrying out his usual routine, he opened the door and came suddenly upon the lady of the house before she had dressed. She reprimanded him severely and told him he should always knock before entering. These recollections had great emotional power. They were related to much earlier emotional experiences.

I may cite here a fragment of a dream produced during the analysis: "'I was passing through a factory yard on my way home. A white man volunteered to conduct me through the factory grounds. As I walked with him I remarked that it was good to have short-cuts, for they saved a lot of time in getting home." Associations to this dream led to an

early experience. On his way home from school, the shortest route was through a park, a "white park", where colored boys were reluctant to go for fear of being molested by older white boys. Once he saw a drove of white Mexican children on a road. One little Mexican girl was nude. His mother commented on Mexicans. Other episodes went back to his fourth year.

Mary's mother, Mrs. Dalton, is a very interesting figure. In actual memory she corresponds to the mother of the young woman in whose house he had a job. He said that his memory of her remained "nebulous" even after the whole scene was clearly recalled.

You will remember that in the novel Mrs. Dalton is blind and cannot see. But at the crucial moment she is present and becomes aware that something extraordinary is going on.

Who is the woman who is blind but not blind enough, who does not see but who watches the secret acts of the hero? In Wright's life it may be sufficient to say that the ego ideal was largely derived from the mother, and not from the father. And the very symbol of the seeing eye that is blind fits the mother image.

An analysis of this scene in *Native Son* would be incomplete without an account of how he came to use the name Dalton for the white family. At the beginning of our experiment he could not account for it. But sometime later he said he recalled from the days when he worked in a medical research institute that "Daltonism" is a form of blindness. Had the name Dalton perhaps something to do with the blindness of Mrs. Dalton? There is also a deeper and more dynamic association. Daltonism – and that is what he did not remember – is of course a technical term for a form of color blindness. I need not point out to you how emotionally charged the expression "color blind" is in relation to a novel that plays in the South.

While hitherto it has only been assumed, on the basis of more or less valid reasoning, that the unconscious plays an important role in literary creation, the present study gives proof in a specific instance. The data presented here are sufficient to show that unconscious material enters definitely into a work of art and can be recovered by analytic study. Only unconscious factors with a high emotional value are significant in literary creation. The dream process runs through the creative process.

Comparison of the long-forgotten memories presented in this study with the self-explanation of *Native Son* in "How Bigger Was Born" show that the latter is a conscious rationalization. Psychoanalytic studies of works of literature in which the author was not available may also in many instances have been such rationalizations based mainly on theory.

(*) Read before the American Psychopathological Assn.'s 34th Annual Meeting in New York City on June 9th, 1944.

(1) "*The Matricidal Impulse. Critique of Freud's Interpretation of Hamlet.*" *Journal of Criminal Psychopathology.* II. (4). '41. 455.
Dark Legend. Duell, Sloan & Pearce. New York. 1941.
(2) In *Uncle Tom's Children.* Harper and Bros. N. Y. 1938.
(3) Harper and Bros. N. Y. 1944.
(4) Harper and Bros. 1940.

THE PSYCHOSIS THAT PSYCHIATRY REFUSES TO FACE*

HERVEY CLECKLEY, M. D.

Augusta, Georgia

Though all of us are familiar with the type of patients who, according to the official standards of our Association, are placed in the category *psychopathic personality*, we are all willing, I dare say, to agree that the category is somewhat vague and that many of these types have little in common. It would be difficult, if not impossible to discuss several diverse things at once or as an entity; so I shall confine myself to patients showing one disorder that, in my own experience, has seemed to follow a distinct pattern. This disorder has impressed me not as some vague borderline reaction but as a genuine and definite psychiatric disease and one that in its severe expressions incapacitates the subject no less than the well recognised psychoses.

This type of disorder is, I am sure, familiar to all of you. Dr. Ben Karpman[1] has described such cases accurately and vividly and several years ago argued for their recognition as patients with a real mental disease for which he suggests the term anethopathy. Many outstanding characteristics of this personality disorder are brilliantly portrayed by Charles Jackson in a current novel, *The Lost Week-End*[2]. An important analysis of a typical case will soon be published in Robert Lindner's book, *Rebel Without a Cause*[3]. Despite your already excellent acquaintance with such patients, it might be worth while for the sake of concreteness to consider very briefly an example.

This young man of thirty has been married for eight years. He has three children. On being asked how he spent his leisure time during recent months, he replies that he has been reading a good deal. Among other things he has just finished all of Thackeray's novels. Questioning reveals at once that he is entirely unfamiliar with any of these

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works and, in fact, is able to give only one title correctly. He is not discernibly embarrassed by being caught in such gratuitous lying and pretense. Not long afterwards in the course of the discussion he looks the examiner in the eye and speaks with apparently deep sincerity of "giving his word" and seems to take it for granted that this will be regarded as a valid pledge and settling the matter. The history as given by others reveals that he has obtained and lost dozens of good positions. In the last of these he made an admirable record for eight months, earning as a salesman approximately twice as much as any of his competitors and far more than he and his family needed for any of the ordinary comforts of life. He then began to sell his commodity under the cost price, running up his sales to a fabulous figure. Even a stupid man would know perfectly well that this would not profit him and this extremely clever man was quite aware that he would promptly be discovered and discharged from his excellent position, if not sued and perhaps imprisoned.

Though he had regularly succeeded for a while in his other occupations, he always lost them through similar and apparently willful folly and misconduct. In the course of his successful business with one company he made trips each week-end to nearby cities and, one might say to while away his time, he legally married three respectable young women during a period of two months, representing himself to each of them as single and impressing all three as a sincere and honorable man though not as a particularly passionate bridegroom.

After hundreds of extraordinary humiliations, years of neglect and mistreatment, after scores of his gross infidelities, lies piled upon mountains of lies, after getting him out of jails repeatedly and vainly sending him to psychiatric hospitals, this man's wife, finally having become convinced that her husband did not care for her and would not change, took steps to free herself from him by divorce. He had given no evidence of genuine interest in her or the children whom he often cursed and frightened and did not support or protect. He protested, however, with vigor against her action:

"I do not suppose I'll get proper judgment here from you and yours. I will *Up There* and if I'm wrong I'm willing to suffer for eternity. I believe I've suffered enough here. I'm not at all afraid to die. I want to die. I am going to die soon. I have nothing else to live for on this earth. Not even the children. With the position you put me in, to them I will be a shame. I have threatened suicide before. This is not

a threat. I am going to commit suicide soon. I do love you. I have never loved anyone else since childhood. You will never forget me. When I kill myself my blood will be on your hands . . . It will be heavy on your heart and soul and wrongs will all be righted on judgment day."

He goes on to say:

"Would any normal person willfully do things to bring himself and his loved ones nothing but disaster? And when there was no chance of any other gain—mental, moral or financial? God will be my judge that I did not know what I was doing. I was not well then, I know."

This man's memory was unimpaired; he had never shown any of the signs by which a psychosis is technically established. I don't believe that he suffered particularly, as most of of us know suffering, in the disasters he brought upon himself and his wife; but I am strongly inclined to agree with him in his claim that he is not normal. This claim is made only perfunctorily, I think; for he continued to behave exactly as he had behaved before. He does not understand just how he is disabled and what is the nature of his disorder nor, I think, does he care except in the most superfical degree; but I hardly see how we can deny his claim that a man in his "right mind" would not do what he did. Though his words are only a ruse to influence his wife, they happen also, I cannot deny, to hit on truth.

The hundreds of others whom each of us has seen, the hundreds so similar to this man, represent, it seems to me, a valid reaction-type, a personality disorder as genuine and distinct as any other described in our text-books. Sometimes in their teens they steal a valuable watch and swap it for an ice-cream cone. When sent off to school with an ample allowance, they may sell all their clothes, squander the money on soda-pop or candy bars, for which they have shown no particular desire. And on being expelled for a succession of serious, shameful and uninviting offenses, they tell their parents with cool self-assurance that their clothes fell off the bus and were lost in a creek. Their calmness and apparent sincerity make even such a story as this sound plausible and they tell it as if they meant to be believed despite their awareness that the parent has already been correctly informed by the authorities.

They steal, lie, cheat and betray others for no reward at all or for so little reward that the stimulus is almost inconceivable. They go out of their way to put themselves into disgraceful and ignominious positions and often seem to relish bringing off their most outlandish fiascoes

as conspicuously as possible. Unlike orthodox criminals or people merely selfish and callous in the ordinary sense, they often take inadequate precautions to protect themselves and are not consistent in any effort to avoid detection and punishment.

No matter how many reverses they suffer, no matter what losses of money, security, freedom, etc., they sustain, they do not modify their behavior; though they are able very accurately to point out the "lesson" they say they have learned and to convey a convincing impression of their resolution to mend their ways.

They seem, in fact, so unaware of genuine intentions, of a conviction that can move one to act, that one can hardly say they are in the ordinary sense insincere. One sometimes feels that they are unable to realize there is an inconsistency between what they promise and what they do, between their universe of lies and the obvious and sharply contradictory facts. An excerpt from a letter by one of these cases recently under observation may bear out my point.

This young man after typical behavior at home was sent to live with his uncle and aunt in another city. In the course of a few months there he failed all his subjects in school, was caught a dozen or more times stealing. What he stole was more often than not something of little use to him. He stole athletic letters which he had no right to wear, a valuable set of mechanical drawing instruments which he soon threw away, a silver pitcher (from his aunt) which he sold for a dollar and a half. He often wandered about the streets or stood, idle and bored, on corners, coming in at 2 and 3 A. M. despite the fact that he knew he would be punished. He always had an excuse which, though not infrequently ingenious, could be and nearly always was readily checked and proved false.

Once he made the excuse of a fanciful accident sustained while wrestling in the gymnasium. "When I spit up blood they took me to the hospital. Dr. ——— kept me there for a couple of hours." He gave the story in solid detail and it was difficult for his relatives to doubt it, especially in view of the fact that the physician named was the one he knew they were to interview the next day. He showed no embarrassment in the inevitable detection. After a church service he went and spoke with the minister, professing quietly but with indications of deep sincerity, a "conversion". The two prayed together and the clergyman

was naturally impressed with the wise and manly discussion our subject offered about his plans for the future. A few days later, during communion, he stole one of the little goblets used in the communion service.

Several days after borrowing five dollars from an interne who had taken an interest in him, he came to the emergency room and hung around for a while. Finding the friendly interne for a moment idle, he playfully pulled a package of cigarettes out of the exposed pocket on his jacket. Replacing this, a moment later he reached over and caught up the fountain pen clipped in the same pocket.

"Put my pen back," the interne said carelessly, for his attention was now involved in giving instructions to a nurse. "I'll need to use that pen in a minute," he added without turning his head.

The young man complied, fixing the pen carefully back in the pocket. Shortly afterwards he left the emergency room. A few moments later the interne discovered that twenty dollars, which he had just received as his monthly salary, was missing.

During subsequent discussions with the interne, with the psychiatrist and with the clergyman previously mentioned, he denied having taken the money. He not only denied it consistently but his candid gaze, the excellent and convincing reasons he expressed for not doing such a thing, his apparent dignity and earnestness, his spurning of any word or gesture that might be called "over doing it" or laying it on too thick" and his lack of discernible glibness, all served to give an impression of honesty that few if any innocent men could muster to defend themselves.

While praising his aunt and uncle to their faces for their kindness and interest, he wrote letters home complaining of outlandish and imaginary mistreatment by them, adding that his uncle referred to his mother as a "dirty bitch." He wrote about saving money he made at a part-time job in a drug store, now that he had overcome his former bad habits. Frequently in these letters he offered good moral advice to his brother: "In times when you are about to lie or find fault with anyone, just hold up your head and say 'no' to yourself. The narrow path is a hard, long trip but I've been on it now long enough to be positive it's best. If I've got the grit and determination to go to the top, you can do it too."

After a steadily mounting succession of follies the relatives felt they could deal wth this boy no longer and sent him home. A week later this letter was received:

"Dear Doctor:

Arrived home safe and sound. I was really astounded at the great change in this small, typical midwestern town as I pulled into it on Sunday . . . I'm getting along fine here at home with Mother and Father. I feel like a different fellow. Dr. ———, I don't know how I'll ever thank you for what you did for me down there. It was my chance to straighten out and I took it. I believe I can say I did a good job of it. I don't know whether I could have done it alone. But the main thing is it's done and I want you to know I appreciate your help.

Well, I have to go now for it's about time for school . . ."

All of us know these cases. This is not the occasion to describe them in the fullness of detail that might be necessary before laymen in a court. We know them and we cannot but admit they are seriously disordered organisms. Yet we do not officially admit this. The diagnostic label we are required to place on these patients automatically stamps them as sane and competent and excludes them from State Hospitals and from other institutions for the mentally disordered.

Our standards, I realze, allow us the privilege of calling them *Psychopathic Personality with Psychosis* and so getting them temporarily into institutions. Once there, however, they fail to show the academe signs that we traditionally accept as establishing the diagnosis of psychosis and they are promptly discharged. With all due respect to the occasional case of this sort who develops some other condition that we can officially call psychosis, I believe few of us will deny that a very great majority of these patients carry on their inadequate, disastrous and antisocial careers without benefit of any additional "psychosis", episodic or otherwise. Their fundamental disorder that we cannot by our present standards pronounce as a psychosis, and which establishes them as competent in the courts, is what brings about the abnormal behavior, the psychotic behavior. We cannot deny that the behavior is a grossly incompetent and often as fantastic as that of many patients we pronounce psychotic, however much we may quibble about such traditional points as delusions, hallucinations, etc.

I do not believe that we can do much as physicians for these patients, or do much to help their families and communities and the social agencies of the state, until we are willing to accept a real and practical definition of psychosis and give up our scholastic and traditional attitude in this matter. On nearly every other question medicine, unlike law and sometimes theology, concerns itself with actualities, determining its judgments by what is happening and by what exists rather than by what has been written or what can be cited as precedent. In our dealings with these so-called psychopaths, however, like the medieval anatomists who put a text of Galen above the evidence of dissection, we still bow to more or less irrelevant verbalizations[4] while the facts of conduct butt us continually in the face. As to the question of "psychosis", can any of us really disagree with McDougall[5] when he says: "Can the patient be trusted to look after himself and his affairs without undue risk to himself and others? And there is no other criterion."

When one proposes to call these psychotically behaving patients psychotic he is met with objections: A considerable percentage of the population show schizoid, cyclothymic and paranoid tendencies but we do not therefore diagnose them as schizophrenics, cases of manic depressive psychosis or paranoiacs and commit them. I think we should call psychotic and incompetent only those people showing this other disorder who prove themselves so by their conduct. We must insist, however, that in this judgment the reality of their conduct be given first consideration, not the traditional criteria, the verbalized definitions, as is done today.

To insist that a man is sane and competent whose consistent conduct plainly shows him no better able to carry out a safe or acceptable life scheme than many schizophrenic patients impresses me as scarcely less sensible than to say a paranoiac or a schizophrenic has no psychosis because we find no organic brain lesion that accounts for his symptoms. Fortunately in the latter instance we give more weight to the facts and less to the theory. With the so-called psychopath, however, we still do the opposite. Because we find no delusions, no hallucinations, or other customary symptoms that enable us to explain why he behaves irrationally, and because he can go through the empty form of reasoning correctly in words, we ignore the great and real disorder that he demonstrates spectacularly in his actual life, day after day and year after year.

Who is more abormal, more irrational: the schizophrenic who gets himself into trouble because a voice that he believes is God's voice tells him to carry out bizarre acts plainly against his interest? Or the other man who does the same things without the hallucination or the delusion that makes somewhat understandable the psychotic behavior in the schizophrenic and, for the subject at any rate, makes what he does logical and proper? Before we can ask for better cooperation in the courts and for society to provide some facilities for dealing with these patients we have been calling *psychopathic personalities*, must we not get together and officially admit that they have a true disorder? Must we not agree, when they show themselves grossly incompetent, to call them "psychotic"? There are those who will bitterly object that our definitions do not allow this. I don't think definitions or any other verbal schemes are as important as the heavy and obvious facts of this problem. Perhaps it would not be too much for society to demand of us that we modify the definition.

There may be physicians who will say that since these people can in words define correctly what is generally regarded as "right" or "wrong", that since they "know" what they do is injudicious. illegal, inappropriate and will lead to disaster, we must regard them not as patients but as willful wrong-doers and let the penal authorities deal with them. We have been trying this for a good many years now and I do not believe any of us is pleased with the result. Except for the relatively few who commit crimes of great violence, adequate punitive measures are seldom taken by legal authorities.

All of us are familiar with the usual sequence of events. Dozens of times, scores of times, the subject is arrested for his troublesome or incompatible conduct and perhaps serves short terms in jail only to be released and continue as before. More often his relatives make sacrifices to pay him out of the consequences and he continues without even a brief interruption. In my own experience it has sometimes seemed that the judges, juries and other laymen concerned surmise enough of the truth, despite our own expert opinion to the contrary, to realize that they are dealing with mental illness. At any rate, it is customary in the courts with which I have any acquaintance to let most so-called psychopathic personalities avoid legal punishment on the attorney's claim of incompetency; and even the poorest attorney can present an array of valid and pertinent evidence from his client's past behavior sufficient to

establish incompetency not only for one man but often for a dozen. They are then sent to psychiatric institutions where they are promptly, and correctly by our present definitions, discharged as sane and competent. Surely all of us have seen this farcical cycle repeat itself dozens of times in the career of a single patient. We cannot blame the lawyers or the laws for this. And we are hardly so foolish as to blame the patient. Can we justly lay the fault anywhere but at our own feet?

Years ago Karl Menninger[6] arguing that something short of an absolute, a black and white *either-or* demand be adopted in efforts to distinguish between the "insane" and the "criminal" suggested that we ask not, "*Is that man responsible?*" but, "*Of what is he capable or incapable?*" I thoroughly agree with Dr Menninger's opinion in regard to misconduct or so-called punishable conduct in general; but I feel that in this case above all others his argument is applicable. It has been frequently pointed out[6] that once even inanimate objects were held accountable for punishment and later pigs and horses were still tried and convicted for crimes. Children, idiots and ever more recently those we class today as the psychotic were in turn recognized as not legally responsible and it became the practice to treat them differently from those whose motives for misconduct we could understand and perhaps share.[6] Even on the basis of the present criteria, that is to say that when we regard as incompetent those who in damaging society gratify no readily comprehensible desire and who, so far as one can see, voluntarily damage themselves as regularly as others, it is hard to see how we can avoid classing severe cases of the sort we call psychopathic personality as incompetent.

It should perhaps be stressed that these patients whom Karpman refers to as anethopaths and who impress me as showing a disorder at semantic levels of functioning, continue to bring misfortune on themselves. I have serious doubts if the sufferng of their wives and children, of their parents or mistresses, trouble them particularly. But I have no hesitancy in maintaining that confinement in jail and prolonged periods on the wards of a psychiatric hospital are distasteful to them. Within the narrow limits of their superficial range of feeling they hate and despise these experiences, are restless and sometimes almost frantic for release. Yet, as all of us know, they promptly, sometimes immediately, misbehave seriously, and apparently for no purpose, in just such a way as to make it necessary for them to be returned to their wards or their cells. As Karpman[1] points out, they, unlike cases of mental deficiency, are not unaware of the consequences that will follow their acts.

I do not think that admitting these people are incompetent would leave society unprotected against their bad conduct. It seems to me that society has exceedingly poor protection at present. Even those psychopaths who also have major sadistic or otherwise destructive tendences and who commit murder and unnatural crimes on children are too often at present released from prisons on probation and allowed to repeat their tragic deeds. If the real and serious nature of their inadequacy were recognized, they could be segregated and prevented from accomplishing these repetitions.

If we could fully admit that they are mentally ill, they could then be treated as patients and their freedom in the social group be determined not by arbitrary and irrelevant sentences for punishment, which they would evade, and which, even if not evaded, are without effect or sensible purpose, but by the pertinent criterion: "*Of what is he capable or incapable?*"[6]

If this criterion could be accepted by us in our efforts to determine whether or not a patient is psychotic, it would perhaps be easier to obtain recognition in the penal codes and in the courts for the partially competent or partially responsible cases. Many types showing deviations and inadequacies of a different nature from the group I regard as of primary importance are catalogued also under the heading *Psychopathic Personality*. These schizoid, cyclothymic and paranoid personalities who are not sufficiently disabled by their disorders to be diagnosed as schizophrenia, manic depressive psychosis or paranoia and committed for protection and treatment should, it seems to me, be recognized as less competent than the ordinary man. The law still demands that we be governed by a two-valued logic in these matters,[4] that we assume a man must be either totally sane and competent or totally psychotic and irresponsible.[6] While this is very "logical" in a verbal system, it unfortunately does not regularly apply to the actual material with which we deal.[4]

I have observed many homosexual people who show as much responsibility and who, in general, conduct themselves as inoffensively and as judiciously as the ordinary person we call normal. We see others whose judgment is impaired and whose goals are distorted in varying degree by the peculiarities of their erotic drives and their difficulties in expressing themselves in a world where they do not readily fit. Some homosexual cases, of course, show the utter irresponsbility, the complete disregard for the rights of others and the unteachableness that I have

tried to advance as characteristic of a fundamentally different disorder that often is sufficiently disabling to be recognized as a psychosis. On the other hand many of these other cases, those whose behavior seems devoted more faithfully and consistently to failure in general, to self-destructon at social and personality or semantic levels than to any other aim, sexual or otherwise, may at times indulge in homosexual relations and give the erroneous idea that their fundamental disorder is homosexuality.[7] In my own experience I have observed many so-called psychopaths who more or less casually had relations with true homosexuals or carried out perverse relations with others not strongly influenced by any deviated tendency. Such relations apparently meant little to them, often affording even less satisfaction than the feeble and superficial reactions with which such people respond in any love relation with the opposite sex. I have often received the impression that psychopaths blundered into their perverse sexual activities from the same regressive impulses that lead them into their other schemes for failure and social degradation.

One case who vividly illustrates this is an aristrocratic and "brilliant" young man, an honor graduate of an excellent college, who had for several years shocked his family by consistently seeking out every imaginable way to get into trouble and place himself in an ignominious positions. He was definitely not a man with the sort of drives we see in the real homosexual nor did he possess any of the other personal characteristics of the homosexual male. He had occasionally when drinking indulged without any particular pleasure in overt sexual acts with other men but far less frequently than with women. The incident that led to his being examined consisted in his picking up four unwashed negro field hands and driving with them to a tourist camp where he took them into a cabin and was shortly afterward detected in the act of fellatio. He took the oral role. We have all encounterd homosexual and other perverse acts in schizophrenics and in paretics where the act was plainly a manifestation of the general disorder rather than a clue to its major cause.

If we are to distinguish the type of case I have discussed chiefly, it would be profitable to give the disorder some less generalized and more appropriate name. We have mentioned Karpman's term, *anethopathy*. This or any other term which does justice to their status so seriously disordered patients would serve a useful purpose. The strong and consistent impression I have received from working with such cases is that their fundamental psychopathology consists in an inability to evaluate, a failure to feel and realize what other people feel and realize in

their personal and social experience as human beings. None of the goals that attract us, none of the sorrows or shames that chasten us, none of the important fulfillments that we seek because we feel, more or less independently of any verbal arguments, are for us worth while, – none of these influences enter sufficiently into such patients' realization or conduct to make them do otherwise than they do. They use the same words that the most understanding and eloquent of men might use in talking about all these things But they use them with as little relation to anything in their own inward experience as a case of semantic aphasia, who may correctly repeat or produce spontaneously sentences that have a meaning to which he is blind. This type of patient, called an anethopath, by Karpman, shows no demonstrable disorder at rational levels. It is only at a more complex level and in a subtler way that he is inadequate. The term semantic as it is understood in semantic aphasia and, still more pertinently, as it is used by Korzybski,[4] suggests better, I think, than any other the basic deficiency in this puzzling condition. It is, I am convinced, a disorder primarily at semantic levels[6], an inability though one sees the facts and the consequences, to appreciate or be moved by them. What matters to the normal man matters not at all or so little that it influences the patient's conduct insufficiently.

Severe cases of this sort if classified as *semantic psychosis or semantic dementia* could, I am confident, be better treated by the courts and by our psychiatric institutions. If we could admit officially that this disorder exists, whatever we may choose to name it, and be in a position to call those who are rendered incompetent by it just as incompetent as they prove themselves to be, I have little doubt that facilities would be provided to protect both themselves and society from their deeds. Whether these facilities should be psychiatric units operated in connection with penal institutions or special sections of State Hospitals is of less urgent importance than that some provision for the patients be made. The details could be worked out by competent psychiatric authorities.

Here at the one hundredth anniversary of the American Psychiatric Association I must say that it would surprise me little if some years hence our descendents looked back on us with astonishment similar to that we sometimes feel in remembering that not long ago all the people we recognize today as psychotic, and, a little earlier, pigs and even trees

were dealt with as if responsible and punishable by the ordinary standards of our penal codes.

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PROGNOSIS AND PREVENTION OF UNTOWARD EVENTS ON THE BASIS OF THE DRIVER'S CASE HISTORY

An Expert's Opinion with Remarks on the Usefulness of Pathographology

WLADIMIR ELIASBERG, M. D.
New York City

The most painful curse visited upon humanity is that in the wake of blessings there seem to follow, inevitably, the scourges. Thus, again in our times, the joy of speed and overcoming distances was followed by an appalling increase in drunken driving, reckless driving, and accidents. When the conscience of the authorities and the scientists turned to the investigation of such cases, some prejudices had to be swept away. Statistics show that it is not the age group 50 and over that contributes most to accidents and traffic offenses, but, on the contrary, those groups in the prime of their lives, between 20 and 40.[1] On the whole, the greater responsibility and experience of the older groups overcompensate the physiological factors which certainly favor the younger drivers. On the other hand there is a psychological factor, of what, in neurology, has been called anasognosia. Many persons in responsible positions suffering from organic diseases, particularly neurological disease or disease of the circulatory system or arteriosclerosis with or without hypertension are accustomed to high levels of asphyxia and consequently to disregarding their symptoms, such as dizzy spells, weakness, fainting, etc.

Turning to the factor of prophylaxis we should keep both the statistical and psychological factors in mind. Radicals of prophylaxis are asking for regular examination for drivers and for compulsory withdrawal of the license, should there be discovered any serious change. Such radicalism, apart from being very hard on a great number of persons who, neither in the past did nor in the future will incur any traffic difficulties, will also meet with legislative difficulties. Experience does not vindicate a prophylactic extremism.

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[1] Cf. Alan Canty(1), Selling (15, 16), Fahrenkemp (7).

The surgical method of cutting deep into the normal tissue is indicated only when we have no better method of control. The following case of a Manic-Depressive driver will show that in psychiatry at least, we have more sensitive criteria.

Mr. D. K., 28 years of age, recently desired a statement concerning his ability to drive. His driver's license which he had been granted at 18 years of age had been turned in to the authorities by a hospital and he had been put on one year's parole. This was done because he had been treated for a mental disorder. As a driver he had never had any accidents, nor had he ever made any claim for damages. Apart from a military, he had never drawn any pensions. Mr. K. wants his license returned to him because his mother, after a stroke, thirteen years ago, is paralyzed and cannot leave the home without his driving her.

Family History

Apart from the mother's stroke which she suffered at the age of 54 it is without particular interest. The father is in perfect health and has been working as cook for 30 years. One brother holds an officer's commission with the Flying Forces.

Patient's History

Had good marks in elementary and high school. Got his high school diploma in 1932 and went into business. In 1937 he had an episode of abnormal elation and was sent to a State Hospital where he stayed for 5 months. After this he worked fairly successfully as an assistant field manager. After his induction early in 1941, he joined an engineer's detachment as a truck driver and at the same time was coach of the basketball team and ran a column in his outfit's newspaper. Early in 1942, he was sent to a northern emplacement. The job he had to fulfill there kept him more and more 'away from the fellows.' He gradually felt 'awfully' tired so, at the suggeston of his Lieutenant, he saw a psychiatrist. The Lieutenant had been surprised at Mr. K.'s complaints that he couldn't do his job anymore. The complaints, at that time, consisted in inability to cheer up or to be with the fellows and in ideas of suicide. That was in the early summer of 1942. At that time, there were continual rains; "The sun out there comes out only once in a while." It was suggested that he be released from that lonely outpost, but that didn't help him greatly and it occurred to him that "he was doing the same thing he had done in 1937". In the late summer of 1942 he was definitely relieved and transferred to an army hospital.

In the early winter of 1942, he was honorably discharged from military service. His physical condition at that time was good and early in 1943, the Superintendent of the State Hospital informed him that the return of his driver's license could not yet be recommended because "It is essential for his own safety and that of the community to be sure that he is going to stay free from nervous symptoms before he begins to drive a car."

No syphilitic or other venereal infection; Wassermann repeatedly taken, negative.

Self Description of Character and Complaints During the Two Episodes

Outside the episodes, he qualifies himself decidedly as being an outgoing (not seclusive) extrovert. During the first episode these traits were as he states, "much more so." He is easy at making friends. He wouldn't say that, on an average, he is cool and collected, although in the episode in the northern regions, as already mentioned, he could not mix with the fellows. The onset in 1937 was gradual, in 1942 more sudden. A question as to self-accusations in 1942 he answers, "I think I had delusions of grandeur." As evidence for this he mentions that he was trying for officer's candidate school and wrote in his letters as to how easy it was to become a General. On direct question as to self-accusations, he can give no evidence. His sleep was troubled both in 1937 and in 1942. He lost weight in 1942 and regained it. He does not remember whether this was the case in 1937. Most of the time in the hospital he just sat around and when asked what had happened to him, he didn't like to say.

At the time of depression, he was not interested in girls. "Now, it is all right," he has dates, etc.

Smokes cigarettes, does not abuse alcohol.

He has been workng since early 1943, 48 hours a week at full salary and is also on a commission basis. On his job, he has to see people and to talk to them. He thinks that everything will work out very nicely. He has been drawing a military pension from the late winter of 1942 to early spring of 1943, on the basis of 100%, and from then until late summer 1943, 50%. He does not feel that his present condition would justify any pension, anymore.

Complaints at present – none.

Experience As A Driver

No accident in 10 years of driving. There was particularly no accident in 1937 and no accident in 1942. He makes the following statement: In the summer of 1942, he was ordered back to truck driving and at that time, he didn't like it because "he worried about things and thought that something might go wrong with the car." He tried to do as little driving as possible. He always felt relaxed at the wheel. He never had any fainting spells while driving.

Findings

Height – 6 ft.

Weight – 145 lbs.

K. is rather lean. The hair is not thinned, no baldness. The aspect, looking at the posture and the configuration of the chest and the long neck, is that of an asthenic-athletic.

Pulse in standing position – 76. After awhile, with no exercise but with obvious emotional strain – 88.

No increase of the heart figure.

Thyroid not increased.

No increased tremor of fingers.

Hands and fingers somewhat wet.

Knee jerks brisk, equal.

Strong red dermographism.

No other gross neurological abnormalcies.

Cholesterol examination could not be done.

I had the neuro-ophthalmologist, Dr. A. Kestenbaum, New York, examine Mr. K. His report is as follows:

Fundi: Normal

Visual acuity: 20/20

Refraction: Slight hypermetropia.

Light and convergence reaction prompt in each eye.

Pupils are round. No hippus.

Anisokoria in physiological limits.

Higher tonus of the sympathetically supplied tarsalis superior and tarsalis inferior muscles in the right eye than in the left.

Sympathetic tonus of the right pupil stronger than in the left one; sympathetc tonus in the right lid muscles stronger; slight left exophthalmus.

That means a little, still physiological imbalance of the sympathetic tonus of the two sides (Not a Horner or sympathetic irritation).

Psychological Findings

Mr. K. had chosen the address of the doctor whom he had asked for an examination from a list of neeurologists which he had found in the Library. In other words, no personal contact, recommendation, etc. had guided him. His behavior during the examination was friendly, cooperative but, while not stiff, always with a certain reserve. When the necessity arose of giving him a special examination of his eyes he was somewhat perplexed but did not balk.

Handwriting Findings

In the handwriting sample of September 29th those traits which are usually thought of as characteristic of either depressive or manic phase were absent.

Picture 1 shows parts of a letter written in June 1942, during depression. The difference between this sample and the recent one is (Picture 2) that the depression writing is more pasty; the loops are on the whole, more daubed; the lines, especially the last paragraph of this letter, are more closely knitted and more curved. The letter of September 1943 looks on the whole more stiff. The left margin forms an absolutely straight line while, in the older letter, it broadens toward the end. More impressive than the differences are the congruences between the letters. Of the signs of Bond[2] we find in both specimens a certain slowness (round i dots put rather low and mostly exactly over the i's) but there are also, in both, i dots placed high, far away, and to the right. The pressure is strong. The letters are rather narrow. The under-lengths are longer than the upper lengths. There is much angularity, even double angles or arcades. The writing is on the whole simple. The tendency toward the right side is not very strong. The writing is regular but there is certainly a lack of harmony in the lines. Signs of Release are the pastosity and the continuity. In other words, while there are not very many signs of a disease in the handwriting, there are distinct signs of the character of the patient. The prognosis of the driver's record from its character is not possible. Small wonder then that the same

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[2] Lewinson, Thea Stein, (10). S. A. Lewinson, Thea Stein and Zubin, Joseph (11).

prognosis is not feasible graphologically.[3] There is, however, on the basis of the graphological record, an evaluation of the seriousness of the process which is beyond any doubt, if the onlooker will compare these specimens with others which we reproduce from a German and a French publication (See pictures 3, 4, 5, and 6).[4] Unfortunately no speciments of the elation episode in 1937 could be located.

Summary of Findings

An athletic asthenic young man with slight imbalance of the sympathetic tonus expressing itself in hyperhidrosis and the described phenomena at the eyes, also in brisk muscle reflexes and strong red dermographism.

The handwriting is in perfect congruence with the opposing marks not leading to perfect harmony, on the contrary, each type of mark holding its own as it were.

Diagnosis

Manic-Depressive disease in an athletic asthenic individual with sympathetic imbalance and certain imbalance of character traits. The intervals between the episodes were rather long, the episodes themselves rather short. If we compare the data gathered in this case with those indices for the prognosis for the recovery as established by several authors in the last years,[5] the following factors in our case are favorable or unfavorable, respectively.

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[3] See Demmler, H. (2).

[4] The German specimens taken from Martin Heinen (9), Picture 3 representing a depressive patient and picture 4 a severer degree of elation.

The following two are from Rogues de Fursac (12).

Attention should be paid to the fact that the characteristics of the Manic-Depressive disease are fairly equal in all three groups.

Saudek, Robert (13, 14) used to maintain that the expression of character traits is so much influenced through the national script that it would be impossible to directly compare English with French or German handwritings. While this statement seems exaggerated for characterological graphology, it is certainly untrue for patho-graphology. For details see, Eliasberg, W. (3, 4).

[5] Cf. Gildea, Edwin F., and Man, Evelyn B., (8).

FAVORABLE	UNFAVORABLE
Average level of schoolmarks, social adjustment and earning power.	Slightly leptosomic physique.
On the whole, normal sexual attitudes.	Imbalance of personality.
Outgoing personality.	Slightly split personality reflected in behavior and handwriting.
Thinks that he's always been able to keep close friends.	
Subjectively and objectively warmth of temperament.	
Vasomotor disturbances.	
Lack of hallucinations.	
Sleep disorders.	
Acute onset.	
Short duration of attacks.	

The favorable factors greatly prevail over the unfavorable. In other words, the prognosis in the case is a good one as to the frequency of attacks, the duration of the attacks, and a good recovery.[6]

Do attacks of Manic-Depressive disease of the described type and does, particularly, the last attack of our patient justify the withdrawal of the driver's license? Statistics do not show a particular involvement of Manic-Depressives in driver's accidents, hit-and-run driving, etc.[7]

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[6] In Manic-Depressives of advanced age one would also have to look for additional signs of arteriosclerosis with or without hypertension, fainting spells, etc., in other words, cardio-vascular complications of the Manic-Depressive disease. Such a complication might dim the prognosis of the disease and, at the same time, the record of the driver. In our case, no such considerations were necessary although hypertensive disease, of course, also may happen in the age of our patient.

[7] Also in terms of the theory of the accident-proneness as developed by modern clinical psychology, the prognosis of the Manic-Depressive in general and of Mr. K., is is not a bad one. Whatever the analysis of accident-proneness may render, the basic fact is the antecedent accident. It is this fact that is missing here.

In Dr. Lowell Selling's statistics[8] the neurotics with their complexes, the feeble-minded, the alcoholics and the paretics are encountered much more often than the Manic-Depressives and the Schizophrenics. In the 500 cases seen before the Detroit Traffic Court, there was only one case of Depressive-Mania as against, e. g. 255 alcoholics, or 344 under-average intelligence quotients.

It can easily be understood that the traffic record of Manic-Depressives is a good one and may even be better than the record of the average driving population. Whether the onset is acute or insidious, the patient will in the melancholic phase, lose his interest in driving which happened also in our case. Our patient tried to do as little driving as possible. The phase of elation on the other hand, even if it is severer differs from the pseudo-maniac phase in paresis in that the patient never completely loses control. This again was true in our case in the episode of 1937.

If on the other hand, the incoherence of the personality is stronger, then no such coherent activity as driving is possible, anyway. There is, to sum up, no reason why an increased danger to himself or to the community should be suspected and why undue hardship should be inflicted upon the mother of the patient.

The more sensitive criteria which we spoke of in the introduction of this case, are furnished by minute and thorough clinical observation which has been the royal method of medicine through the ages. In the experts' opinions too, the main pillar must be the clinical one, while statistics may be used to buttress the observed facts or else egg us on to show why, in the case at hand, different conditions prevail. The expert's opinion is not the field of probabilities in the mathematical or philosophical sense, but that of "truth and verification."[9] The general theory may be compared to a rather wide net. In the expert's opinion, the meshes must be knit so closely as to match with the conditions of the individual case. The expert's opinion therefore, should be used to gauge the theory and to fit the theory more tightly to the facts, finally also, to stir new theories.

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[8] Cf. Selling, Lowell S., (15, 16).

[9] See Eliasberg, (6, 5).

Summary

1. Experts' opinions must be based on the clinical observation of individual cases or groups of such cases. Statistical data related to the case at hand should be known to the expert. His proper task, however, is to establish the reasonable and verifiable truth not the probability.

Generalities have to be passed through the strainer of the individual case to separate, as it were, coarse-grained theories from those that will meet the individual truth. In this way, the expert's opinion may contribute to the development of the theory.

2. Graphology has mostly been made use of in clinical medicine to demonstrate organic-neurological disorders and changes, e.g., Parkinsonism. Patho-graphology should be called upon wherever the tinge of psychological, patho-psychological or psychiatric influences may be important. This is the case, e.g., in the disorders of the heart and the circulation and in the narrower field of psychiatry. Graphological records should be kept as a routine in every case history.

In combination with other methods, patho-graphology proves useful to answer the following questions no 3 b and d.

The patho-graphological characteristics of diseases are practically not related with the national script.

3. The question of the competence of a driver who recovers from a disease should be handled on the basis of (a) the general prognosis of the disease at hand, (b) the general psychological picture of that disease: In what way does that disease generally influence the psychological attitudes? (c) the case history, (d) the type of personality and his individual psychological picture.

4. Manic-Depressives are relatively little involved in traffic offenses because the general psychology of the disease (3 b) as well as the psychological type of their pre-morbid personality (3 d) do not promote aggressiveness or accident-proneness.

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Picture I

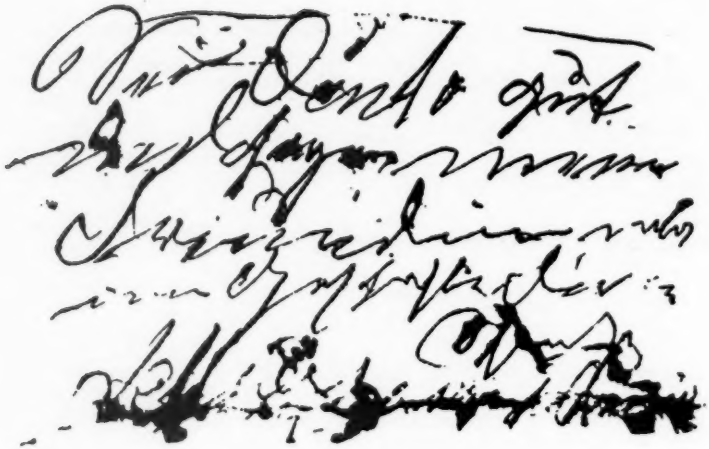
a movie, etc. Incidentally we're quite far from the places in the Aleutians that you read about in the papers; so don't think I am being bombed, or anything like that....

I realize this isn't much of letter, but it's the best I can do considering the circumstances. It certainly seems that more things happen in the Bronx than here... Has anything developed yet due to Pa's registering a few months ago? Does George still come home? Let me know just how things are from time to time.

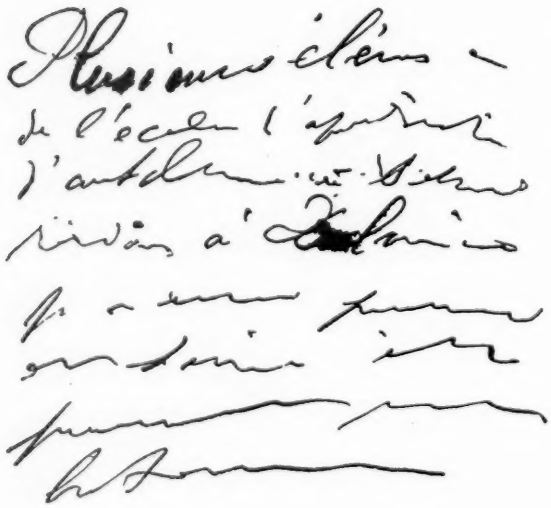
Picture II

the last letter I wrote from Alaska At the time it caused me great difficulty, as I did not want to complain how terrible affairs were going

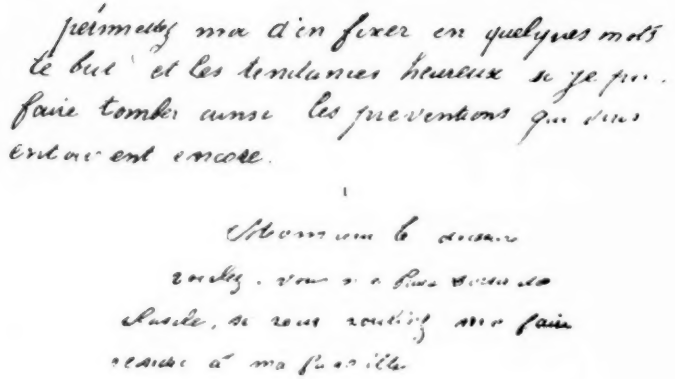
Picture IV



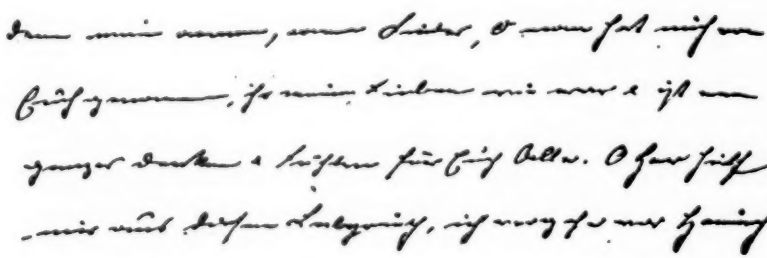
Picture V



Picture VI



Picture VII



Educational Psychotherapy

ALCOHOLICS ARE SICK PEOPLE

A Guide for the Bewildered and Perplexed

ROBERT V. SELIGER, M.D.
Instructor in Psychiatry, Johns Hopkins University Medical School; Assistant Visiting Psychiatrist, Johns Hopkins Hospital; Medical Director, Haarlem Lodge, Catonsville, Md.; Medical Director, The Farm for Alcoholic Patients, Howard County, Maryland

In collaboration with

VICTORIA CRANFORD
Psychotherapist and Rorschach Analyst, Haarlem Lodge, Catonsville, Md.; The Farm for Alcoholic Patients, Howard County, Maryland.

Edited by,

HAROLD S. GOODWIN
Day City Editor, The Baltimore Sun, Baltimore, Maryland

An alcoholic is a sick person. Alcoholism is a symptom of an illness and not a disease by itself. It is a symptom of deep or deeper underlying personality-emotional reactions of varying degrees and types.

For practical purposes, we feel that a person is an alcoholic when he is "handled by alcohol" to such an extent that it takes him out of one or more of the traffic lanes of life. But with this in mind, one is supposed to be a "social" or moderate drinker if he "handles alcohol" so that it doesn't take him out of one of these traffic lanes.

Therefore, one must keep clearly in mind that alcoholism is not a dissipation. This is proved by scientific experience with individuals who had alcoholism as a problem.

Furthermore, it is necessary to keep in mind that all individuals with alcohol problems are not bums or drunkards.

Medically speaking, as we have said, an alcoholic is an ill person—his abnormal drinking results from an underlying emotional conflict,

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* indicates definition appears in Glossary.

conscious or unconscious*. His motivations, habits and reactions are out of balance.

His use of liquor—plus its resulting nervous strains and reactions, and his own nervous pressure—interferes directly or indirectly with one or more of his important life activities. That is, his drinking harms himself, his family, or his standing in the community.

If you have a drinking worry of any sort whatever, it is possible that *you* are an alcoholic. If you are one, or even if you are just in the stage of becoming one, you should act at once to save *yourself*—for the alcoholic himself is the chief sufferer from his illness.

One of the main purposes of this book is to encourage the abnormal drinker to obtain expert aid before it is too late. Drawing on many years of experience in dealing with alcoholism, the author hopes to make the alcoholic understand three things:

1. That he is fundamentally different from other drinkers.

2. That he should seek aid immediately.

3. That he can now find aid through medical science. (Unless he is already in a hopeless state. The authors do not say that all alcoholics can be cured. But many cases that seemed helpless to the layman, or to the alcoholic himself, *have* been cured.)

ARE *YOU* AN ALCOHOLIC?

Before going further, suppose we try to find out whether you are suffering from the illness called alcoholism or whether you are in real danger of becoming an alcoholic.

We have already noted several of the more apparent symptoms of abnormal drinking—that is, the way drinking interferes with the important life activities of the alcoholic. Possibly some of these statements came close to home. In any case, do you dare to take a "screening" examination for alcoholism?

At the end of this article there is a "liquor test" which will help to tell you whether you have reached the danger point in your drinking. The 35 test questions are based directly on the behavior leading up to alcoholism in many hundreds of case histories. Each question deals with a sign that has appeared so consistently in the early records of abnormal drinking that there can be no doubt that it is a danger signal.

Now take the test, carefully. Then have your husband or wife (or a friend) take it for you. If all answers are *No*, you are probably

safe—for the present, at least. But every *Yes* answer is a red light, warning you to put on the brakes.

Remember that these questions refer to very serious matters in anybody's life. If you are losing time at your work, you must know that it can be dangerous. You can't honestly minimize loss of ambition. If your reputation is suffering, it is no light matter. The habit of solitary drinking can indicate a precarious unbalance in your personality: it suggests that you are leaning altogether too much on liquor for support. A person who suffers from the inner shakes unless he continues drinking is a badly handicapped individual. A man who "just has to have a drink" the next morning is certainly misusing alcohol: the craving for the "hair of the dog that bit you" is a serious indication that your overindulgence has reached the stage where it is likely to grow progressively worse.

If you answer *Yes* to certain of the questions it means that you are using alcohol to find an emotional escape from situations in real life that you find too unpleasant; or your dependence on liquor may mean that you yourself are not adjusted to face the normal course of events. In either case, you are using liquor as a crutch to "get by." And liquor is an outrageously bad crutch; when you put any weight on it it not only breaks but trips you up, leaving you worse off than you were before.

Quite possibly, you can name a few individuals who have ignored one or more of the danger signals in the liquor test for years and have apparently come through unscathed. No doubt you also know individuals who consistently ignore red lights at grade crossings.

But suppose you and your wife (or friend) have been able to answer *No* to all the questions. Fine! Continue your drinking if you so desire. On the other hand, if one or more red lights show up, stop drinking at once—at least temporarily—and seek competent advice regarding yourself and your future drinking from a psychiatrist* or good mental hygiene clinic.

If You Are an Alcoholic

Does this suggestion surprise you? Does it strike you as not only unnecessary but rather drastic? Even if you have a serious drinking worry, or are an outright alcoholic, you may be saying to yourself, "Now just a minute, doctor! I may not be able to handle my liquor but I'm not nuts. It's not going to help *me* to sit crosslegged on the floor and weave baskets. And, besides, I don't drink because I was scared by a nightmare at the age of four."

This, of course, is a frequent reaction of alcoholics—and others—who know little of the developments in modern psychiatry. They assume that psychiatric treatment is solely for "crazy people."

Unfortunately, the success of the best psychiatric methods in dealing with the problem of alcoholism is too recent to have attracted wide attention. And even those relatively few persons who understand that psychiatry is now grappling effectively with all forms of personality or emotional problems often do not realize its role in helping the alcoholic. As a matter of fact, many physicians themselves are not yet fully acquainted with the medical aspects of abnormal drinking. Many an excellent doctor is himself a controlled drinker and—not being a psychiatrist—has not learned why there are some who are *unable* to use liquor the way he does.

The psychiatrist, in recent years, has applied himself to finding out why. He has searched for the *causes* of abnormal drinking and they have given him valuable clues to the cure. In brief, psychiatry has learned that alcoholism is a *symptom* of an underlying disorder, just as a person who is "ill with a fever" may be suffering from an underlying physical disease which causes the fever. In many cases, neither the alcoholic nor the fever patient is aware of the cause.

The alcoholic's disorder is not "physical" in the usual sense, of course: it is a maladjustment which is both psychological and biological.*

Alcohol comes into the picture as a narcotic*, a pain-killer. In other words, the underlying disorder causes tension, anxiety, restlessness or hostility, which the abnormal drinker, without realizing it, soon learns to narcotize with alcohol.

There is the tense man who wants to drink because it relaxes him. He has been "all wound up." He thinks a few stiff drinks are just the "nerve tonic he needs." Maybe a lot of people or things have been getting under his skin. He may be torn between desires and responsibilities. He is pent up. At the end of the day he has the sensation, perhaps, that his tempo is violently speeded up, that his nervous system is racing.

Everyone is familiar with the use of alcohol to numb anxieties, whether acutely active or just gnawing in the back of the mind. The worrier tries to escape from himself, to "drown his troubles." He either seeks to forget, temporarily, or to make his mind look at his troubles through a rosy haze.

Perhaps the drinker is driven by only a vague restlessness, an inability to be composed, mentally and physically. His thought processes

while sober make him bored and uneasy. He can't settle down to doing anything and he seeks to escape from himself in an alcohol-induced activity.

Then there is the feeling of hostility as a cause of alcoholism. The drinker, consciously or unconsciously, rebels against people or circumstances. Many times he does not realize that he is feeling resentful. At other times the apparent hostility is sufficiently recognized for him to head for a bar with some such thought as, "To hell with it all—I'm going to get drunk."

What Really Drives You To Drink?

It is obvious that it is only half the picture to say that an alcoholic drinks to narcotize tension, anxiety, restlessness or hostility. Something must cause those states. There must be an underlying conflict of some sort which is discovered through careful, systematic psychiatric study, observation, analysis and therapy.

Studies of a great many pathological drinkers* disclose one or more of the following reasons for their excessive use of alcohol:

1.

As an escape from situations of life which the drinker cannot face. (1. *Psychogenic, with psychogenic frustrations.*)

Sometimes these situations take the form of what people call "troubles." The drinker's money worries may have him down. He may hate his job and feel discouraged about his future. Perhaps he has lost the good opinion of his friends. His home life may be full of bitterness, nagging or sadness. Maybe he has been unhappy in love, or someone's death has left him feeling alone.

These are a few of the outstanding difficult situations. But lesser factors in his environment can also pile up on him and hit a tender spot in his make-up. Perhaps his life is humdrum and none of his early dreams came true. Hundreds of factors in his individual world can cause either unrealized strains or conscious unhappiness, or both.

2.

As a result of a personality insufficiently adjusted to the normal course of life. (2. *Genogenic plus psychogenic*)

In this instance, the drinker has been unable to adjust *himself* to the

more or less average difficulties of living. Perhaps he is constantly handicapped by excessive shyness, or is so sensitive that he is forever being made miserable. Maybe he cannot satisfy his sexual desires, or is troubled and worried by his unusual desires. Possibly he suffers from very strong feelings of envy and inferiority. And so on. Such failures to adjust harmoniously to life are frequently caused or aggravated by an abnormal set of influences in early life.

3.

As a development from controlled, social drinking to pathologic drinking.

In this development the habit of drinking becomes a dominating force in the life of the drinker, often by a process imperceptible to him. The drinker learns to prefer alcoholic unreality to sober reality. Because of this, he becomes the victim of an addiction. His use of alcohol—formerly controlled—gets gradually out of control, partly because his drinking creates difficult problems which he tries to meet with still more drinking. Factors which may contribute to his addiction include a fundamental restlessness or discontent, an inability to "snap back" from alcoholic bouts as he grows older, and a drinking environment which sets a pace which he can no longer "take."

4.

As a symptom of one of the major mental abnormalities (psychoses, commonly known as insanities.)

Some alcoholics suffer from a major type of mental illness, but every form of mental illness has been found among alcoholics. In other words, the alcoholism is a symptom of their illness and not a cause, and they would need psychiatric care even if they had never touched a drop.

5.

As an escape from incurable physical pain.

This alcoholic, of course, drinks to narcotize the pain, and also to narcotize the results of his fears relative to the future.

6.

As a symptom of an inferior intellectual and/or totally immature emotional make-up. (Genogenic)

This person's emotional and intellectual immaturity or inferiority is so marked that he is a handicapped individual, even without the complication of alcoholism. He may drink because he likes alcohol, knows he cannot handle it but simply cannot care. He does not suffer from the recognized major mental disorders, and is likely to be called merely weak or irresponsible, whereas he is a "poor egg." His behavior usually demonstrates extreme carelessness of obligation and lack of ability to be reliable or take responsibility, and as a result he is continually in jams of one sort or another.

These reasons for drinking are found again and again in cases of alcoholism. Sometimes a psychiatrist can readily recognize two or more of these factors at work in one individual.

At other times, it is true, it is difficult to single out any outstanding factors which cause the pathological drinker to use liquor. But it invariably becomes evident that he drinks to relieve a certain vague restlessness, set up by the frictions in his life resulting from internal, external (or both) adjustments. Consciously or otherwise, he does not like the way things are going. He (or his ego) is dissatisfied, perhaps bored, perhaps disappointed. He (or it) wants a change, that is, a relief or release from these so-called anxieties and their resulting behavior, and learns to get it through or via alcohol. So, from these psychodynamics, plus habit, the alcoholic psychopathology develops.

Some people have interpreted the production of the anxieties, etc., which need to be narcotized, in terms of an intense urge to self-destruction; of overt or latent homo-sexuality (from a medical-psychological understanding of the unconscious), or of early psychic trauma (wound or injury).

To get back to *your* problem. You have taken the liquor test. Assume that it has revealed danger signals in your drinking habits. It may be that you will temporarily have to watch your step, or you may already be an individual with a permanent alcohol problem.

It is almost impossible for you to decide where you stand. Because of the subjective situation, excessive drinkers are usually unable to see what is happening or has happened to them. This fact is proved by plenty of evidence, in scientific studies and in everyday life. We have discussed some of the psychodynamics, or underlying "causes," of al-

coholism. Perhaps through this discussion you have become aware that this problem is by no means unusual; that it is a very serious one; that psychiatry today is not exclusively occupied with the mentally sick or insane, and that psychiatry is not a fad.

The psychiatrist is not a mystic. He doesn't go into semi-trances with you. He doesn't use a Rube Goldberg apparatus to measure your inner soul. Nor, contrary to some popular prejudices, does he give your problem a fine, fancy "double-talk" label and expect you—as well as himself—to call that the cure.

The psychiatrist uses common sense in a scientific, helpful way. He is able to be helpful because of: (1) his long experience with a wide variety of human problems in which there are varying types and degrees of mental and emotional illness; (2) his training and his understanding of personality make-ups and their emotional reactions in interpersonal relationships; (3) his ability to properly evaluate conscious and unconscious motivations and, in turn, to objectively utilize these significant tools and factors. In treating the individual who has an alcoholic problem, the psychiatrist uses these tools and factors in either causing the cessation or curtailing the production of the anxieties, or in developing a change in attitude so that the individual can be able to flow in the traffic lanes with maximum efficency and also (through this and re-educative measures) (A) not need, or have to resort to, the use of the (for him) narcotic—alcohol. (B).

If you elect to consult a psychiatrist he will determine whether you are a social or a pathological drinker. As we have seen, this is a distinction of the utmost importance. To put bluntly one aspect of this distinction: If you have become a pathological drinker, you must never drink again. Even if you were a moderate, controlled drinker for many years, you cannot recapture that ability. You have changed. You have become "psychobiologically" allergic to liquor, and for you it has the effect of a pernicious drug*. When you use alcohol, you become "drug-

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(A) During and after treatment a helpful list of guides for this new orientation of thinking and behavior habits is frequently used as a re-educational adjunct. You will find a copy of this list appended.

(B) The psychiatrist's treatment (althugh individual) in general involves: careful selection of patients; a history and examination of the patient, with special tests where indicated; determination of the psychodynamics and psychopathology of the patient, followed by psychotherapy and re-education. The re-education follows commonsense lines, involving certain views, attitudes and insights, including the development of a proper attitude to alcohol and life situations, and a new habit formation which breaks down indirectly the old habit associations.

ged by drink." *Drinking in moderation is an absolute impossibility for an alcoholic.*

But, you may say, if some objective adviser would give an idea of how much you dare drink, you would stick to your limit. In the first place, there is no way for the alcoholic to know in advance just how a specific amount of liquor will affect him. And, secondly, he would not consistently stick to his limit, even if it were possible to fix one that was satisfactory from all points of view. The capacity for handling alcohol not only varies greatly with different individuals but with the same individual at different times. Therefore, the first drink is the one too many, and that one too many causes him to lose all control of his drinking.

If the psychiatrist tells you that medically you are an alcoholic, that goes for beer and wine, as well as whiskey and other hard liquor. Liquor is liquor, in any form. Many an alcoholic has gone on the rocks because he insisted that he could drink beer, even though he was convinced he couldn't handle hard liquor.

Perhaps you tell yourself that you are "not the sort" of person who could be really ruined by liquor. Don't believe it. Liquor is no respecter of persons, once they have become pathological drinkers. Don't think it is "manly" to be able to hold your liquor. Don't imagine that you can "beat liquor" or exhibit your will-power by taking just a couple of drinks now and then. For you, it just won't work. Sooner or later—and probably sooner—it will again be a case of having one too many. And then you will be off again.

There are a few alcoholics whose minds have been forced to accept the fact that they cannot handle liquor at all. But most of them are rather shocked when they are told that they must avoid alcohol for life. Their reaction is usually something like this: "I know I've had some trouble with liquor, but Great Scott, I'm not that bad off. With a little help and time I can learn to drink moderately again."

The patient's reaction is entirely human but it is entirely incorrect. All serious students of alcoholism agree that it is hopeless for the abnormal drinker to aim at moderation. Complete abstinence is his only salvation.

Indisputable evidence shows that if your drinking habits are genuinely bad they will get worse. One of the tragedies of the general misunderstanding of alcoholism is that drinkers permit themselves, or are permitted, to get into real jams before they know what is happening to them. A great many do not seek help until it is too late to change

their habits or prevent deterioration of their brain cells or avoid other disasters to their bodies and nervous systems. Alcoholism, like numerous illnesses, must be taken in time or the sufferer becomes too far gone for help.

Perhaps, however, you are the type of drinker who has already become overly depressed about his condition. You have seen with some horror the changes in your behavior or mental processes. You have begun to doubt whether you are "worth saving." You think you have become a sort of bum, that alcohol has brought out your true colors and that they are ugly ones.

Don't leap at any such conclusions. Such reactions are often found in alcoholics. It is simply not true to say that alcohol always shows a person's real character. This fallacy is recognized in such common expressions as "under the influence" and "he wasn't himself." And don't take refuge in some such generalization as "it is not unintelligent to be discontented." It *is* unintelligent to seek contentment in alcohol.

ALCOHOLISM DOESN'T MAKE SENSE

Right now, no doubt, you are appalled at the possibility that you may be advised to stop drinking. Life without liquor would be very dreary, you tell yourself. No matter what alcohol has done to you, you still want it and probably feel that somehow you can eventually control it.

There are several things to be said on that subject that may prove helpful, but the primary fact is this: If you *are* an alcoholic you have no choice but to stop drinking permanently. It's that or nothing. For you may be sure that if you don't stop, all your hopes and desires will come to exactly nothing. It isn't an open question that permits you to weigh pros and cons. It is useless to tell yourself that "you must think it over." An alcoholic can't afford to continue with liquor any more than a diabetic can afford to experiment with sugar.

If this seems a bitter pill to you at the moment, it can't be helped. But if the pill cannot be sugar-coated, it can be made far less bitter than you expect. One of the reasons you want alcohol, or think you "need" it to "keep going," is because of the state you are now in: like other drugs, alcohol makes ever-increasing and insistent demands on its addicts. Moreover, if you seek expert medical care, you will receive help in proportion to your need. A psychiatrist is also a doctor who

will give you certain treatments, tests and even medications;§ an adviser who is thoroughly familiar with the sort of problems you have and the emotions you are subject to, and also a friend (anchor) with whom you can talk easily (ventilate) about the things that are on your mind. You will be astonished at how well he does understand you. And don't think that he isn't used to dealing with complex personalities and highly organized, "thoroughbred nervous systems."

Whatever your philosophy of life, alcoholism doesn't make sense. It is possible that you appear to be deliberately and admittedly a pleasure seeker, with no thought for anyone else, no desire to benefit your community or society, no interest even in doing a good job at something for its own sake. The motivations behind this are the business of the psychiatrist. It is, further, his business to point out that abnormal drinking brings the drinker infinitely more misery than pleasure. The pleasures of the senses become dulled, because liquor is essentially a depressant* and is being misused when used as a narcotic. The depressant process is true of mental and emotional enjoyment and one finds that periods of artificial exhilaration become briefer and briefer, and the mood of the drinker often changes abruptly to anger or morbid* depression. Even in the relatively brief periods of pleasurable intoxication, the realities that the drinker is trying to escape tend to intrude themselves ever more sharply into his consciousness.

If you are the sort who takes a certain pride in his work, and derives satisfaction from a job well done, it is obvious that alcoholism is making you botch your job—either outright, or compared to what you could do. If you get most of your happiness out of giving pleasure to your family or others, there is surely no need to mention again how liquor is defeating your purposes. It may be added, moreover, that not only can your drinking inflict unhappiness, shame and perhaps poverty on those who are dear to you, but it can cause *them* to suffer definite forms of mental illness.

If you are religious; if you are ambitious; if you want health; if you would like to pull your own weight in the social order—you can't tell yourself that liquor hasn't helped to wreck your plans again and again.

Some pathological drinkers apparently develop a more or less un-

§ Medication for the alcoholic patient may include for a time the use of sedatives under careful medical control, an increase in sugar intake, heavy does of Vitamin B, as well as various other agents for acute conditions.

conscious urge toward self-destruction. The most sensational form of this urge is found in the person who frankly says he is "drinking himself to death". Obviously he is in dire need of medical treatment. Equally obviously, he has chosen a prolonged and painful method of suicide. No matter how much one part of his maladjusted, masochistic* nervous system may "enjoy" the process of self-torture, other parts of his being suffer the most intense misery.

In other words, alcoholism is not an efficient constructive or destructive agent in following one's instinctual or other drives, or attaining through one's drives certain goals in life. The alcoholic is kidding no one, including himself, if he says, "I may be going to the dogs but I'm having one hell of a good time doing it." One might say, he's having a hell of a time, period.

TAKING THE MENTAL HURDLES

Perhaps you yourself are willing to admit the last statement. You are ready to take the long view of things and face up to the realities. Yet you still have certain notions about alcohol that you haven't been able to fit into the picture of yourself as a non-drinker.

Alcoholics fall back on the widespread myth that drinking is an essential part of "gracious living", that one can't be civilized though sober. This is an idea that has been widely propagated (but also reduced to absurdity) in advertisements, fiction and movies. One suspects that the majority of the more sincere spreaders of this gospel are rather naive. It is like saying that smoking a pipe is always essential to gracious living. A lot of gracious people drink and so do a lot of ungracious people. But a lot of both kinds don't.

Tangled up with this idea that drinking is somehow smart is the usual connotation of the phrase about "carrying your liquor like a gentleman." It is apparent that the phrase also connotes that gentlemen don't drink enough to become ungentlemanly – and if they can't drink without ceasing to be gentlemen, they don't drink at all.

Likewise, the alcoholic usually has memories of occasions when liquor seemed to sharpen his wits, polish his manners and infuse him with *savoir faire*.. To believe that any such thing ever happened is to believe a half-truth. Liquor does not sharpen wits; it dulls them. Often, it does make a drinker more talkative. It may make him say things he would not think worth saying if he were sober. It may put him in the frame of mind to think of clever or amusing things but it handicaps

him to a greater or less degree in expressing himself. His mood becomes brighter at the expense of dulling his mind. The effect of his wit or cleverness is usually in direct ratio to the alcoholic consumption of his listeners, and it nearly always sounds a little thin when repeated the next day. Many a man has said, "It sounded funny then," or "Well, it seemed a good idea at the time."

It would be foolish, of course, to deny that social drinkers find alcohol an aid to conversation and conviviality. But the important element here is the *social* drinking. For the pathological drinker, the periods of amiability and repartee grow shorter and shorter. He quickly becomes maudlin, tiresome, incoherent, ugly or downright idiotic.

This is no argument against social drinking, naturally. It does provide enjoyment and stimulate amusing interchanges. But the author must insist, in the interests of truth, that the best epigrams and the wisest statements are conceived without benefit of alcohol in the vast majority of cases.

In addition to various exaggerated and romantic notions about liquor's role in "civilization", the alcoholic who realizes that he should stop drinking foresees himself beset by insidious reactions in his day-to-day life. He sees his friends continuing to drink, many of them without apparent harm to themselves, and he finds it hard to assimilate the fact that he himself *can't* drink. His "set" drinks, there is a lot of drinking in his community; the whole world seems to drink. He is assailed by the feeling that it is the normal way of life. He overlooks the hundreds of millions of people in the world who don't drink, the millions who only think they can drink (and thereby create a serious social problem), and the large numbers who drink rarely or who have tired of drinking at all.

The tumult of those who do drink undoubtedly obscures the non-drinkers. If percentages were available it would probably not be found that the generations now living are the hardest-drinking crowd that ever inhabited the earth(§), but due to the pressures and strains of modern living, with a streamlined tempo, criss-crossed social values, ad infinitum, the results are apparently becoming more and more malign.

Other mental hazards faced by the alcoholic include the attitude of both relatives and friends who simply do not understand the situa-

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§ There are many forces in our present culture in America which have contributed to making alcoholism a major health problem. The personality addicted, or ready to be addicted, to alcohol is molded by group and individual insecurity in nearly all spheres of life, plus speed, plus quantity of mobility of living.

tion. There is, for instance, the person whom the alcoholic loves and respects but who tells him, "Oh, a drink or two won't do you any harm." There also is the annoying, and sometimes dangerous, type of person who is overflowingly full of good advice, all of it bad. The varieties of stupid suggestions are bounded only by the limits to human ingenuity.

The nosey people will want to know what it's all about when the alcoholic stops drinking. These he may deal with as he thinks best in each individual case, as long as he himself keeps always firmly in his mind the goal of *permanent* abstinence. Perhaps the best general policy is to tell them flatly (if a little vaguely, when indicated) that he has decided that he would be better off without liquor. And there is the joshing friend who may call him a "reformed drunk." This remark hardly calls for more than a laugh or a wisecrack from the "retired drinker."

It is needless to worry about what others will think if *you* stop drinking. You will not be transformed into a prude or a bore, and you will probably learn sooner or later that many people felt that you drank too much, and that they approve and admire your quitting.

One especially virulent fallacy is that you have an hereditary weakness for alcohol. Dismiss this notion from your mind – and don't use it as an alibi for continued drinking. *No one is born an alcoholic. It is probable that a person can inherit an inability to handle alcohol and, because of his physical and constitutional make-up, he never has any business using alcohol. But there is nothing in his heredity that forces him to use it. Psychologically, imitation and identification give many individuals a feeling of this pseudo-inheritance.*

LIFE WITHOUT LIQUOR

Some of these human relationships and fallacies that we have been mentioning may seem formidable hurdles to you at the moment. But you will be surprised at how quickly they become insignificant if you stop drinking.

IF you stop drinking . . . Do you *want* to stop? Are you completely sincere in your desire to stop once and for all?

Put it another way. Do you finally realize that you have no choice *but* to stop? Are you convinced that you would rather quit drinking than go on the way you are?

Perhaps you feel that quitting is an almost impossible task, and that you are "not up to it." But reflect for a moment on the fact that

present-day medicine, for the first time in history, can understand and help many alcoholics.

The alcoholic is similar to other sick people in that he very often doesn't know that he is ill and even when he does, he frequently postpones doing something about it. But there is this difference: the vast majority of alcoholics haven't the faintest idea where to go for help, or even any realization that, in many cases, they *can* be helped.

What is *your* present situation? Things are going from bad to worse, but you can't seem to halt the process. People have plenty to say about your drinking, but they are hardly understanding or helpful. Perhaps your friends or your relatives entreat you to "reform". Perhaps they plead with you to go slow and drink sensibly. Perhaps, in sorrow or in anger, they call you a weakling or a drunkard. You hear that you are dissipated, that you are going to pieces. Sometimes you feel that it is true. You grow angry and depressed. You decide to have two or three stiff drinks to forget your troubles, clear your mind and think things over. And you are off again.

When you drink too much you sometimes tell yourself alibis. You say the liquor "hit you" that particular evening because you were tired, or upset, or not feeling well, or a vague something-or-other was on your mind. You decide to slow down. But you don't.

We will assume that this situation has finally become intolerable, that you earnestly desire to be cured *and that you now have no mental reservations.* Unlike the alcoholics of all past generations, *you* can go to a doctor for understanding and help. In the past, alcoholics were considered doomed – barring a miracle. An insignificant percentage managed to take the pledge and keep it, perhaps with the aid of a temperance society, or as a result of strong religious or family influences. Even in many of these cases, however, the former alcoholic – although luckily ridding himself of the harmful effect of liquor – still suffered from the underlying disorder which originally caused him to drink abnormally.

Medicine itself found alcoholism one of its most baffling problems. For centuries it adopted a hands-off, fatalistic attitude toward the problem of abnormal drinking. This feeling of "once an alcoholic, always an alcoholic" persists, understandably, in a great many medical circles today.

But medicine finally began to grapple seriously with the problem of alcoholism because it became increasingly apparent that it had some connection with mental and emotional disorders. Early experiments

involved much trial and error. One method that was tried, and found wanting, was the attempt to taper off the alcoholics, often in an effort to transform them into moderate drinkers. When a medical pioneer named Forel, late in the 19th century, began to treat alcoholics without alcohol, he was laughed at by people who said his patients would die like flies.

Many early methods of combatting alcoholism involved mass treatment, or "alcohol drink cures." These were based on the mistaken theory that all types of patients could be treated alike. There was also the program of brief periods of desaturation for the drinker, which merely meant keeping the alcoholic away from liquor long enough to sober him up and quiet some of his jitters, and then turning him loose for another bout with liquor. (Unfortunately, these methods still have not altogether died out.)

Even American psychiatry, with few exceptions, long looked upon alcoholism with more or less hopelessness. It is only in the last few years that a growing number of psychiatrists have realized that a carefully selected number of patients can be guided to total abstinence by dispassionate and individualized treatment.

Any alcoholic who is not too far gone can now take advantage of this new development in medical knowledge. The benefits of abstinence will surprise the alcoholic who achieves it. Odd as it may sound to the abnormal drinker in his present state, there is a good deal to be said for the normal life, devoid of the artificial elements created by a misused narcotic. The abstainer is neither a martyr nor a hero.

In a sense, the swift disappearance of the typical alcoholic miseries is one of the earliest and most striking benefits of abstinence. Their absence feels good – in the same way that it feels good when a prolonged pain ceases suddenly. No more dread of hangovers. No more alcoholic depressions and remorse. An end to the nervous horrors, the jitters, the headaches, the nausea, the butterflies in your stomach.

Perhaps you have gradually come to take all of these miseries for granted. They seem to you almost usual to the course of life. The fact that some people do not suffer from them may seem as remote and impersonal to you as the aromas in a Persian marketplace. Fellow humans who have good nerves, energy and ambition strike you as a little obnoxious. And anyone who stays in pretty consistently good spirits seems disgustingly healthy and even a bit of a bore.

You have simply forgotten what the world looks like when not seen through an alcoholic fog. Abstinence is not a panacea for all human

ills but it means that you can again really enjoy food, get restful, untroubled sleep, and wake up without hating the fact that you have become conscious again. It nearly always means better health, more energy, renewed ambition, happier relationships with those around you. You can expect your work to improve and, other things being equal, your earnings to increase. A not unimportant item for most people is the saving of the money that alcoholism costs.

One of the most fundamental satisfactions in convalescing from alcoholism is the rapid acquisition of new interests in life. If you are like most alcoholics, your old interests have been gradually slipping away and you are no longer really keen about much of anything. You have lost most of your zest for intellectual pleasures as well as for the normal forms of entertainment and relaxation. This zest will come back to you, if your mind has not already been ruined by alcohol. Perhaps you do not believe this prediction? If you don't, it is rather eloquent of the state that you are in, and you will have to accept it on faith – supported by the fact that the world contains a great many people who are intensely interested in a great many things.

Another satisfaction, minor but definite, is the fact that sobriety gives you a slight edge in some ways over even the social drinker. It would be silly to over-emphasize this advantage, and the authors certainly are not compaigning against social drinking. The social drinker gets a lot of fun and often numerous benefits from his drinking, and whatever relatively slight penalty he has to pay for the results he considers an excellent investment. Nevertheless, it is only factual to point out that social drinking has some disadvantages and the alcoholic who has become an abstainer would be more than human if he did not take some satisfaction in them.

Even social drinkers sometimes drink too much, waste time, lose sleep and spend more than their budget for entertainment can stand. Occasionally they say indiscreet things and make otherwise unfortunate remarks. There are times when they try to mix drinking with business dealings or important personal matters and find that the consequences are unhappy – because alcohol has dulled their perceptions or altered their moods.

Even so, the authors are more than willing to admit that these are minor and normal hazards to an entirely justifiable indulgence. It is solely with the alcoholic that they are concerned. And, in the hope of helping the alcoholic, they repeat:

You are suffering from an illness. That illness can now be treated with reasonable hope of success in a great many instances. If you delay seeking treatment, you are taking a terrible risk.

Prolonged alcoholism can ruin your mind, destroy health and cause violent and alarming reactions; debase your character, and cause definite mental aberrations that may be either temporary or permanent. The results can include a complete physical breakdown and behavior involving serious crime.

Even if you sincerely desire to stop drinking, but attempt to do so without medical assistance, the chances are that you will be unable to continue to abstain. The underlying disorder that made you an alcoholic in the first place will probably drive you to drink again. In the common-sense re-education of the abnormal drinker, under psychiatric guidance, abstinence is a big step forward. But it is only the first step of a reorganization of yourself that will be the most important thing in your life.

GLOSSARY

1. *Allergy.* A susceptibility in an individual to a substance that is usually harmless to others.

2. *Biological.* Pertaining to the functions of living organisms or the science which treats of them. In psychology the emphasis is on mental processes and in biology on physical processes. The term "psychobiological" indicates the interaction of these processes.

3. *Depressant.* That which lessens functional activity or depresses vital force; a sedative.

4. *Homosexuality.* Interest in, or love for, persons of one's own sex. It is pathological only when it *replaces* love for a person of the opposite sex. It is perversion only when it involves sensual gratification. If it is *overt,* it has reached one of these stages. If it is *latent,* it may or may not ever reach a pathological, or perverted, stage. When a person is called a "latent homosexual", it is usually because the strong influence of a member of the opposite sex has *resulted* in the person's acquiring mental or emotional characteristics of the opposite sex. Thus

a man strongly influenced by his mother may be handicapped by a so-called feminine sensitivity and lack of aggressiveness – handicaps that may cause sensations of shyness, inferiority and envy.

5. *Masochism.* Strictly, a condition in which a person derives sexual pleasure from being physically hurt or subdued. The term is now applied to the enjoyment of any type of physical or mental pain.

6. *Morbid.* Caused by or denoting a diseased condition of body or mind; especially, taking an excessive interest in matters of a gruesome or unwholesome nature.

7. *Narcotic.* Strictly, an agent – usually opium or its derivatives – which produces profound sleep or stupor. It is used medicinally to give relief from physical or mental anguish.

8. *Neurosis.* A nervous disorder in an apparently well person. Symptoms include fears, obsessions, anxieties, mental and physical weaknesses, feelings of inadequacy or exhaustion, twitching muscles. In a neurosis no organic illness or abnormality can be found.

9. *Pathological.* Diseased or abnormal, in the sense used here.

10. *Pernicious Drug.* A substance used for its effects on the bodily functions or nervous system but which, because of its nature or misuse, is harmful and habit-forming. Examples are cocaine, morphine, opium. The alcoholic uses liquor as a narcotic. Strictly speaking, a "drug" is a substance used medicinally. Liquor's medicinal value for anybody is much exaggerated, but for the alcoholic it is definitely "bad medicine."

11. *Psychiatry.* "Mind healing", in the literal sense and original usage. But the science of psychiatry, a branch of medicine, is no longer limited to treating the major mental illnesses; it is now very largely concerned with treating all forms of emotional difficulties and allied personality problems.

12. *Psychological.* Pertaining to mental activities or to the science of the human mind.

13. *Psychosis.* A mental disorder; any prolonged form of mental derangement in which the normal personality of the individual is com-

pletely lost and he is unable to understand or respond normally to his environment. Symptoms include elations, depressions, stupors and systematized delusions.

14. *Unconscious.* Not known or felt to exist. "The unconscious" consists of urges or wishes, which the individual is not aware of and cannot remember, but which may affect his conscious mental processes and his behavior.

The Liquor Test

The Questions	NO GREEN GO		YES RED STOP	
	YOUR ANSWER	YOUR WIFE'S (HUSBAND'S) OR FRIEND'S ANSWER	YOUR ANSWER	YOUR WIFE'S (HUSBAND'S) OR FRIEND'S ANSWER
1. Do you require a drink the next morning?				
2. Do you prefer to drink alone?				
3. Do you lose time from work due to drinking?				
4. Is your drinking harming your family in any way?				
5. Do you need a drink at a definite time daily?				
6. Do you get the inner shakes unless you continue drinking?				
7. Has drinking made you irritable?				
8. Does it make you careless of your family's welfare?				
9. Have you become jealous of your husband or wife since drinking?				
10. Has drinking changed your personality?				
11. Does it cause you body complaints?				
12. Does it make you restless?				
13. Does it cause you to have difficulty in sleeping?				
14. Has it made you more impulsive?				
15. Have you less self-control since drinking?				
16. Has your initiative decreased?				
17. Has your ambition decreased?				
18. Do you lack perseverance in pursuing a goal since drinking?				

THE LIQUOR TEST

The Questions	NO GREEN GO		YES RED STOP	
	YOUR ANSWER	YOUR WIFE'S (HUSBAND'S) OR FRIEND'S ANSWER	YOUR ANSWER	YOUR WIFE'S (HUSBAND'S) OR FRIEND'S ANSWER
19. Do you drink to obtain social ease? (In shy, timid, self-conscious individuals.)				
20. Do you drink for self-encouragement? (In persons with feelings of inferiority.)				
21. To relieve marked feelings of inadequacy?				
22. Has your sexual potency suffered since drinking?				
23. Do you show marked dislikes and hatreds?				
24. Has your jealousy, in general, increased?				
25. Do you show marked moodiness as a result of drinking?				
26. Has your efficiency decreased?				
27. Has your drinking made you more sensitive?				
28. Are you harder to get along with?				
29. Do you turn to an inferior environment while drinking?				
30. Is drinking endangering your health?				
31. Is it affecting your peace of mind?				
32. Is it making your home life unhappy?				
33. Is it jeopardizing your business?				
34. Is it clouding your reputation?				
35. Is drinking disturbing the harmony of your life?				

COMMON-SENSE RE-EDUCATIONAL GUIDES FOR THE ABNORMAL DRINKER

1. He must be convinced *from his own experience* that his reaction to alcohol is so abnormal that any indulgence for him constitutes a totally undesirable and impossible way of life.

2. He must be completely sincere in his desire to stop drinking once and for all.

3. He must recognize that the problem of drinking for him is not merely a problem of dissipation, but of a dangerous psychopathological reaction to a (for him) pernicious drug.

4. He must clearly understand that once a man has passed from normal to abnormal drinking, he can *never* learn to control drinking again.

5. He must come to understand that he has been trying to substitute alcoholic phantasy for real achievment in life, and that his effort has been hopeless and absurd.

6. He must recognize that giving up alcohol is his own personal problem which *primarily* concerns himself alone.

7. He must be convinced that at all times and under all conditions alcohol produces for him, not happiness, but unhappiness.

8. He must come to understand that the motive behind his drinking has been some form of self-expression, some desire to gratify an immature craving for attention, or to escape from unpleasant reality in order to get rid of disagreeable states of mind.

9. He must understand that alcoholic ancestry is an *excuse*, not a reason for abnormal drinking.

10. He must realize that any reasonably intelligent and sincere person, who is willing to make a sustained effort for a sufficient period of time, is capable of learning to live without alcohol.

11. He must fully resolve to tell the truth and the whole truth, without waiting to be asked, to the person who is trying to help him—and must be equally honest with himself.

12. He must avoid the small glass of wine—i.e., the *apparently* harmless lapse—with even more determination than the obvious slug of gin.

13. He must never be so foolish as to try to persuade himself that he can drink *beer*.

14. He must never be so childish as to offer temporary boredom as an excuse to himself for taking a drink.

15. He must disabuse his mind of an illusions about alcohol sharpening and polishing his wit and intellect.

16. He must learn to be tolerant of other people's mistakes, poor judgment and bad manners, without becoming emotionally disturbed.

17. He must learn to disregard the dumb advice and often dumber questions—of relatives and friends, without becoming disturbed emotionally.

18. He must recognize alcoholic day-dreaming—about past "good times," favorite bars, etc.,—as a dangerous pastime, to be inhibited by thinking about his reasons for *not* drinking.

19. He must learn to withstand *success* as well as failure, since pleasant emotions as well as unpleasant ones can serve as "good" excuses for taking a drink.

20. He must learn to be especially on guard during periods of changes in his life that involve some emotion or nervous fatigue.

21. He must try to acquire a mature sense of value and learn to be controlled by his judgment instead of his emotions.

22. He must realize that in giving up drinking he should not regard himself as a hero or martyr, entitled to make unreasonable demands that his family give in to his every whim and wish.

23. He must beware of unconsciously projecting himself into the role of some character in a movie, book or play who handles liquor "like a gentleman," and of persuading himself that he can—and will—do likewise with equal impunity.

24. He must learn the importance of eating—since the best preventive for that tired nervous feeling which so often leads to taking a drink is *food*—and must carry chocolate bars or other candy with him at all times to eat between meals and whenever he gets restless, jittery or tired.

25. He must learn how to relax naturally, both mentally and physically, without the use of the narcotic action of alcohol.

26. He must learn to avoid needless hurry and resultant fatigue by concentrating on what he is doing rather than on what he is going to do next.

27. He must not neglect care of his physical health, which is an important part of his rehabilitation.

28. He must carefully follow a daily self-imposed schedule which, conscientiously carried out, aids in organizing a disciplined personality, developing new habits for old and bringing out a new rhythm of living.

29. He must never relax his determination or become careless, lazy, indifferent or cocky in his efforts to eliminate his desire for alcohol.

30. He must not be discouraged by a feeling of discontent during the early stages of sobriety, but must turn this feeling into incentive to action which will legitimately satisfy his desire for self-expression.

31. He must not drop his guard at any time, but especially not during the early period of his reorganization, when premature feelings of victory and elation often occur.

32. He must understand that, besides abstinence, his real goal is a contented and efficient life.

33. He must appreciate the seriousness of his re-education, and regard it as the most important thing in his life.

34. He must realize that most people seeking psychological help for abnormal drinking are above average in intellectual endowment, and that, while drinking means failure, abstinence is likely to mean success.

35. He must never feel any of these guides, in any way, to be inconsequential, or secondary to business, play, or whatnot; and must conscientiously observe every one of them, day in and day out.

Latin American News and Comments

by S. B. KUTASH

The 25th anniversary of the founding of the Society of Neurology and Psychiatry of Buenos Aires will be observed during the month of November 1944. A series of scientific meetings will be held to commemorate the occasion and similar societies in Argentina and neighboring countries are invited to participate and send delegates. All communications are to be addressed to the organizing committee, Dr. *Rogue Orland*, President, Dr. *Ramon Melgar*, Vice President and Dr. *Enrique Mó Gatti*, Secretary. Three secretaries have been appointed to organize and coordinate the programs of their respective sections. These are Dr. *E. Kropf* for the psychiatric section, Dr. *S. Chichilinsky* for the neurological section, and Dr. *E. Pichon Riviere* for the psychoanalytic section. Some of the official symposia topics thus far selected are, "Prognosis in Schizophrenia," and "Techniques of Cure in Schizophrenia." Among the many organizations which have already decided to participate actively and to send representatives is the Argentine Psychoanalytic Association, several members of which will present papers.

The *Argentine Psychoanalytic Association* announces the following scientific activities for the remainder of 1944:

1. A theoretical seminar in psychoanalysis to be under the direction of Dr. *Angel Garma* at the Institute of Psychoanalysis of Buenos Aires.

2. A course in psychoanalytic psychiatry under the direction of Dr. *Enrique Pichon Riviere* at the Hospital of Mercy in Buenos Aires.

3. A course in psychosomatic medicine by Dr. *Arnaldo Rascovsky* at a time and place to be announced later.

4. A number of important scientific meetings, theoretical conferences, and technical seminars under the direction of various members of the Association.

At a recent meeting sponsored by the Argentine Psychoanalytic Association Drs. *Celes Ernesto Carcamo* and *Marie Langer* presented a highly illuminating paper entitled, "Psychic Reasons for Sterility." The topic was introduced by the statement that sterility may result from psychic factors in those cases where gynecologists do not find a sufficient organic explanation for the sterility. They traced the history of medical treatment of sterility indicating that at various times physicians have pointed out the possible psychic causation of some types of sterility. Even today popular beliefs hold that the psychic condition of the individual exerts a decisive influence on conception and impregnation.

The highlight of the paper was the author's detailed exposition of two actual cases which they had analysed. Both women presented similar clinical pictures and both became pregnant after a long period of sterility as a result of psychoanalytic treatment. One patient suffered from frequent depressed states while the other came for treatment because she was in a serious state of melancholy. Both impugned their femininity and were orally fixated on the mother towards whom they had a highly ambivalent relationship.

The authors stated that the psychic motives for sterility could be varied in nature but that fundamentally it resulted from psychosexual immaturity of varying degree with an exaggerated mother fixation of oral and ambivalent type. This mother fixation usually adopts two forms: one in which the tendencies are actively expressed—corresponding to a masculine type of sterile woman—and the other in which the instinctive drives are passively expressed as in the woman of infantile type whose sterility the gynecologist explains by a diagnosis of genital infantilism.

Though both of these types of women are also encountered among fertile child-bearing women, the authors maintained that in those other cases the masculine or infantile traits do not cause psychoneurotic conflicts and are not somatically expressed but have instead been incorporated into the individual as character traits which do not show up in the genital structure.

In both patients, the melancholia and the sterility both confirmed the intense, uncontrolled ambivalent mother fixation. When the psychoanalysis succeeded in overcoming the mother fixation, the patients were cured of the melancholia and the sterility disappeared.

During the subsequent discussion, Dr. *E. Pinchon Riviere*, among others, presented a similar case analysed by him. In his patient X–, an epileptic, there was also a very strong oral aggressiveness.

Dr. *Carlos Bernaldo Quirós*, professor of Juridicial and Social Sciences at the University of La Plata and an eminent authority on Legal Medicine, delivered an important lecture at the Central Ampitheatre of the Faculty of Medicine on November 13, 1943 on the topic, "Love and Medicine in the World's Crisis." A select and numerous audience was present.

Dr. *Luis Jiménez de Asua*, with the collaboration of the Ex-Dean of the Faculty of Juridicial and Social Sciences of La Plata, recommended an Institute of Higher Studies in Penology and Criminology. The Academic Council of the Faculty, in its session of June 15, 1943, approved the plan and the details for its establishment. The Superior Council also gave its sanction at its meeting of September 9, 1943.

The purposes of the new institute are defined in article one of the resolution as follows: "There shall be created the Institute of Higher Studies in Penology and Criminality as a project of this Faculty, which will have as its main purpose the free teaching of the penal sciences and the application and elaboration of connected courses of study leading to a degree in penology or criminology, corresponding to other university professional courses." The following courses will be established: Argentine Penal Law; Legal Processes; Penology and Penitentiary Technique; Criminal Sociology; Criminology; Criminal Psychobiology; Forensic Psychiatry; Legal Medicine, etc.

The curriculum will be divided into two parts. All graduates of any Argentine, American or European university will be able to enroll in the Institute. They would obtain or study towards any of the following degrees: lawyer, doctor of juridicial social sciences or its equivalent, doctor of human medicine, doctor of legal medicine, doctor of

philosophy or its equivalent, doctor of chemistry or pharmacy and doctor of biochemistry. The attendance of theoretical and practical classes in residence will be compulsory (805).

The Institute will be directed by Professor Dr. *Alfredo Molinario.* The first course, which is already under way with an enrollment of about 500 students is taught by the following professors:

Argentine Penal Law–Dr. Alfredo J. M. Molinario

Penal Procedures–Dr. Juan E. Lozano

Penology and Penitentiary Technique–Dr. Edwardo A. Ortiz

Criminal Sociology–Dr. Francisco P. Laplaza

Legal Medicine–Dr. José Belbey

The current issue of the *Reviste de Medicina Legal y Jurisprudencia Medica of Rosario*, Argentina, of which Dr. *Raimundo Bosch* is editor, contains a very complete section of abstracts from world literature in the field of criminal psychopathology. Among the American articles abstracted are studies by Dr. W. G. Eliasberg, R. S. Banay, and G. Zilboorg. Dr. Zilboorg's article "Murder and Justice" appeared in the July 1943 issue of this *Journal.*

Proceedings

...of...

The Association for the Advancement of Psychotherapy

Officers

President: Frederic Wertham, M. D.

Vice President: Joseph Wilder, M. D.

Secretary Treasurer: Emil A. Gutheil, M. D.

Scope and Objectives of the Association

The Association for the Advancement of Psychotherapy was launched five years ago by a group of doctors, who, in naming their organization, expressed the aim of their new enterprise and the hopes which they held for it. During these five years, the organization has grown both in scope of activity and in its membership. We believe that its history may best be told through a simple documentary listing of its activities: its lectures, symposia, forum discussions and seminars. To tell a history of the Association is to tell a story of fresh interests each year, and of new fields explored. It is a story which shows, moreover, that even in the strain of wartime emergency, the Association has been able to devote increasing attention and study to many facets and current problems of the national life.

From its founding, the Association has adhered to certain broad practical purposes. It has endeavored to serve the interests of all physicians who are concerned with the development of psychopathology and psychotherapy. It advocates all forms of psychotherapy which are based upon inductive methods, which evolve from sound clinical observation and which are directed toward the sick individual *as a whole*.

The organization provides a platform where representatives of the various schools of psychotherapy meet and find common ground for discussion of current scientific and practical problems. Here they may present new data and new theories, and may secure constructive criticism upon them. The Association attempts to establish new ties in allied fields as well. It endeavors to realize not only a contact but an intrinsic collaboration in research and practice between psychotherapy on the one hand, and such branches of medicine as clinical neurology, internal medicine, gynecology, pediatrics, surgery, endocrinology, etc., on the other.

The clinical and social aspects of psychotherapy have engaged the special attention of members of the Association. They have endeavored to bring within its focus the recent advances in the social sciences—in Sociology, Anthropology and Criminology. They have given practical cooperation to several movements to extend the services of psychotherapy to the field of functional disorders. It is their belief that the extension of practical therapeutic measures now in use, the study of their clinical indications and the dissemination of this knowledge will be of real aid to the medical profession. Within the scope of the program of the Association are included also the therapeutic aspects of maladjustment in childhood and of juvenile and adult delinquency.

The Association holds monthly meetings at the Academy of Medicine, at which papers are presented by specialists in various fields, viewing their branch of medicine in the light of modern psychotherapy. During the past year, these meetings made a comprehensive examinattion of various aspects of psychopathology. The papers presented covered such fields as Psychosomatic Medicine, Psychotherapy, Applied Psychiatry, Clinical Psychopathology, War Psychiatry and Social Psychiatry. At each session physicians presented papers, the subjects of which are listed at the close of this report.

In addition, the Association helps organize research along clinical and experimental lines. Special lectures, courses and seminars are given for psychiatrists, for general practitioners and for specialists in other branches of medicine; all these are planned to clarify the new data, theories and methods which confront these physicians in their own practices.

During the past two years, the *Forum discussions* have dealt with "Recent Advances in the Psychotherapy of the Child" (1943) and "Present Need for Advancement in the Health Care of Children" (1944). The latter forum discussions were held in conjunction with the Ann

Reno Institute of New York City—and indeed, were attended not only by members of the medical profession, but by teachers, educators, social workers, child psychiatrists and members of the Parent-Teachers Associations. In this way, a larger group was reached and brought into contact with vital and pressing problems of child psychotherapy, and acquainted with the need of better supervision, education and therapy for the young generation. These Forum discussions have been under the supervision and chairmanship of Dr. Ernest Harms. A detailed list of the subjects discussed is given at the close of this report.

The Association has established contacts with large social groups, in order to gain a common platform for the discussion of problems of mental hygiene and prophylaxis. The discussions held within this framework found their expression in one symposium on "Religion and Psychotherapy" and another on "Juvenile Delinquency and Its Treatment," with distinguished speakers from the lay and medical worlds.

One of the most effective instruments of post-graduate training of physicians has been the *Seminars* which during the past year were conducted by Doctors Goitein, Gutheil, Harms, Wengraf and Wolf. The speakers presented in part material of their original research, in many cases for the first time.. An understanding of the broad scope and expert leadership of these seminars may best be gained by the following brief description of their content:

1. A Seminar on *New Methods in Analysis, Testing and Evaluation of Personality by* P. Lionel Goitein, M. D., of the Woodbourne Institute for Defective Delinquents. In this seminar, Dr. Goitein, whose past experience covers extensive work in psychiatry, child guidance, delinquency and personality research, presented his original work on testing ego functions by a three-dimensional analysis of personality. Such concepts as Head-Schilder's "Body Image," Freud's "Superego" and Jung's "Symbolism of the Unconscious" were viewed in the light of Dr. Goitein's own recent studies. An effort was made to clarify for the student the meaning of temperament, character and the instinctual drives which are responsible for the preservation of the normal ego functions. It was demonstrated that resistance, transference, drives and ideals may become ponderable qualities, tensions within measurable psychological proportions.

2. A series of eight sessions on *The Practice of Active Analysis* was held by Emil A. Gutheil, M. D., author of "Psychotherapy for the Gen-

eral Practitioner" (Huber, Bern) and "The Language of the Dream" (Macmillan). Dr. Gutheil advocates an "active" technique in psychoanalysis. The spring term of this seminar was devoted to a discussion of technical problems of active analytical psychotherapy. Although intended primarily for the psychotherapist, the course was of interest also to the general practitioner who wished to become familiar with analytical findings he could use in his own field of psychosomatic medicine. Among the practical cases approached from the analytic angle were one of mucuous colits; one of insomnia; one of ejaculatio praecox. In each case, the differential diagnosis, indications for psychotherapy, course of treatment, psychodynamics, specific technical probems of the case, and other related problems were discussed.

3. A seminar on *Abnormal Traits in Normal Children* by Ernest Harms, Ph. D., editor of "The Nervous Child" and "A Handbook of Child Guidance", was held in twelve double sessions at the Ann Reno Institute. This course was to aid teachers, social workers, and other interested in child welfare in the use of a normal child psychology designed to interpret deviations from normal behavior patterns. Dr. Harms advances the thought that a "normal child psychology" may in time replace a fragmentary and therefore unsatisfactory application of "child psychiatry." This course was approved as an In-Service-Credit course for teachers employed in the public schools of New York City.

Fritz Wengraf, M. D., author of "Psychotherapy of the Gynecologist" (Huber, Bern) devoted eight sessions to the discussion of *Psychotherapy and Gynecology*. In the introductory part of his Semnar, Dr. Wengraf defined and explained the concept of "Neuropathic Constitution," in order to clarify the effect of the psychomotor reflex. The latter gives the physiologic pattern of organ-neurotic disturbances. The general principles in differentiating functional disturbances from organic signs were presented, and stress was laid upon their close interrelationship. The session devoted to psychotherapy of menstrual disorders was opened with the presentation of the psychology of the menstruation in normal and neurotic women. Dysmenorrhea was discussed from the standpoint of the gynecologist, whereupon the psychic aspects of this syndrome were presented. Emphasis was put on the connections of this syndrome with other existing neurotic symptoms. Then the speaker discussed psychotherapy of dysmenorrhea by presenting clinical observations. A discussion of psychic meno-and metrorrhagia, amenorrhea and pseudocyesis followed, and these problems were illustrated by the

analysis of case histories. In the next session, Dr. Wengraf treated the problem of menopause from the etiologic, clinical and psychological standpoint; the therapeutic possibilities of these disorders were also presented. The following session was devoted to the complex theme of frigidity. The speaker offered a definition and classification of this syndrome, whereupon he discussed the effects of endocrine therapy, their pitfalls, the incidence and the difficulties in the correct diagnosis. The well-known neurotic accompaniments of frigidity were compared with specific bodily symptoms and their dependency upon frigidity was stressed. In the following two sessions Dr. Wengraf presented psychopathological aspects of operative gynecology and obstetrics. The eighth and closing session was reserved for the general discussion of technical questions of psychotherapy related to the field of gynecology and obstetrics.

5. A series of talks to a group of high-school students on *Current Problems Confronting the Youth of Today* were given by Frederic Wertham, M. D., President of the Society for the Advancement of Psychotherapy. Dr. Wertham is the Director of the Mental Hygiene Clinic of the Queens General Hospital and author of "The Brain As An Organ" (Macmillan) and "Dark Legend—A Study in Murder" (Duell, Sloan & Pearce). A leading criminologist, he has devoted much study to the social aspects of psychiatry.

6. During April and May, William Wolf, M. D., author of "Endocrinology in Modern Practice" (Saunders) conducted a seminar in *Endocrinology*. Since Dr. Gutheil's seminar on psychotherapy took place during the same period, and a good many of the participants attended both seminars, certain correlating features between the physical and psychological components found in patients with endocrine disturbances could be discussed from both standpoints. The Association which has as one of its principal aims the study of psychosomatic problems, plans more of this type of presentation for the coming year.

During the seven weekly sessions Dr. Wolf gave a comprehensive course in his field. Not that it was fully exhaustive, for in seven evenings only a small corner of the subject could be covered; however, those who attended this seminar (more than 35 participated) felt that what they had learned gave them a much better grasp of the subject so important for the psychiatrist.

An idea as to how the subject was covered can best be indicated by enumerating the topics presented. During the first evening the func-

tions of the endocrine glands in general was discussed. The manner in which they react upon tissues and metabolic activities, and also upon one another was emphasized. Following that the speaker demonstrated that with this as a firm basis rational concepts of diagnosis and therapy can be arrived at without getting entangled in a complicated and awkward methodology. Constantly referring back to these fundamentals, Dr. Wolf critically evaluated many seemingly complex endocrine problems.

Thyroid disturbances were then discussed, both hypo- and hyper-activities, together with their respective implications and treatment. Since the thyroid gland has a different significance in children and adults, these two phases were discussed separately and conjointly.

The next session was devoted to a study of the pituitary gland and of the disturbances attributed to it, as well as of its diencephalic relationship and its connections with other parts of the nervous system. Here the important psychologic effects were greatly stressed. In this connection certain of the subordinate glands and their respective effects upon growth, carbohydrate metabolism, oxygen consumption, etc., were also brought out.

The speaker then turned to the discussion of the adrenal glands. Both the cortex and the medulla and their hormones were taken up. Since many psychologic disturbances are found in people with adrenal dysfuncton, this relationship was given special consideration.

The next topic under discussion was the studies in mineral metabolism: calcium, phosphorus, sodium, chloride. Carbohydrate metabolism was also discussed. Hypo- and hyper-glycemic states were analyzed and the information noted which one can derive from carefully investigating this bodily function.

During the last evening of this series ovarian and testicular hormones and their effects were discussed. Special topics such as menstrual dysfunctions, obesity and underweight were touched upon. Also, the specific relationships between hormone action and vitamins were taken into careful consideration.

It was interesting to note that a goodly number of the participants of this seminar were repeaters, since Dr. Wolf held a series of sessions the previous year. However, since a great deal of his material was new, those who attended the seminar were not disappointed. We hope that Dr. Wolf may have the opportunity to give us another seminar in the

not too distant future, since there is apparently a great interest among psychiatrists displayed in the subject of endocrinology. In due time a notice announcing the coming seminar will appear in this journal.

* * *

So much for past achievements. The Association can look back upon five active and useful years, and trusts that its future may be equally productive. Three stimulating seminars have already been planned for the season 1944-1945: "Hypnosis as an Adjunct to Psychotherapy" by Louis W. Wolberg, M. D.; "Criminal Psychopathology" by Frederic Wertham, M. D.; and "The Schizoid: A Study of Ego Kathexes," by Paul Federn, M. D. A number of lectures and a symposium on "Endocrinology and Psychotherapy" have also been scheduled.

Physicians who wish to join the Association or to attend seminars and lectures may apply to the Secretary of the Society, Emil A. Gutheil, M. D., at 16 West 77th Street, New York 24, New York.

Schedule of Activities

of the

Association for the Advancement of Psychotherapy

Lectures

A. *Psychosomatic Medicine*

Morris Drazin, M. D. "The Interrelationship Between Nutrition and Psychotherapy'" (1942)
Franz Groedel, M. D. "Psychosomatic Relationships in Heart Disease" (1943)
Henry Jordan, M. D. Psychotherapy and Orthopedics" 1942
Otto Lowenstein, M. D. "What will be left of Neuroses in Clinical Medicine (1939)
Joseph Novak, M. D. "Psychogenic Factors in Gynecological Disorders" (1941)
Martin Schreiber, M. D. "The Pathophysiology of Sex Function in the Etiology of Essential Hypertension" (1941)
Max Schur, M. D. "Psychoanalytcal Approach to Internal Medicine" (1941)
Bruno Solby, M. D. "Psychosis in Pregnancy" (case demonstration) (1940)
Commander Marion B. Sulzberger, M. C., U. S. N. R: "Psychosomatic Relationships in Skin Disease" (1943)
Joseph Wilder, M. D. "Psychological Aspects of Spontaneous and Artificial Hypoglycemia" (1939)
A. L. Wolbarst, M. D. Psychotherapy in Urology" (1943)
Wlliam Wolf, M. D. Interrelationship Between Psychotherapy and Endocrinology (1943)
Symposium on Ophthalmology (1944): Edward Hartman, M. D., Vision; Bernard Kronenberg, M. D., Methods of Determining Psychogenic Factors in Disturbances of Vision; Mark J. Schoenberg, M. D., Intra-ocular Pressure; Alfred Kestenbaum, M. D., External Eye Movements; Isadore Givner, M. D., Exophthalmus; Kenneth Gang. M. D., Pupils; Henriette Loewenberg, M. D., Lacrimal Glands.

B. *Psychotherapy*

Gustav Bychowski, M. D. Psychotherapy of Psychoses" (1944)
Emil Froeschels, M. D. "Correction of Speech Disorders" (with demonstration) (1941)
Emil A. Gutheil, M. D. "Can Psychoanalytical Treatment Be Abbreviated?" (1940)
G. W. Hartmann, Ph. D. "Value Theory as Applied to Psychotherapeutic Problems" (1940)
J. L. Moreno, M. D. "Psychodrama" (1939); "The Present Situation in Psychotherapy" (1942)
Augusta Jellinek, Ph. D. "Psychotherapeutic Management of Occupational Disorders in Singers" (1941)
Eric P. Moss, M. D. "Painting Analysis and Graphic Shock" (1941)
Bruno Solby, M. D. "Psychodramatic Analysis and Therapy" (1941)
Livingston Welch, Ph. D. "The Theoretical Basis of Psychotherapy" (Psychoanalysis, Behaviorism and Gestalt Psychology) (1941)
Joseph Wilder, M. D. "Tics and Similar Motor Disorders" (1940); "Facts and Figures on Psychotherapy" (1942)

C. *Applied Psychiatry*

Anna Anastasy, Ph. D. "Psychopathology and Art" (1942)
Frederic Wertham, M. D. "Critique of Freud's Interpretation of a Neurosis: The Case of Hamlet" (1940)

D. *Psychopathology*

Eric Benjamin, M. D. "Child Psychopathology at the Crossroads" (1942)
Frank S. Caprio, M. D. "Psychopathology of Female Homosexuality" (1941)
Charles Davison, M. D. "Psychological Aspects of Disturbances in the Sleep Mechanism" (1944)
Emil A. Gutheil, M. D. "Mechanisms in Compulsion Neurosis" (1939)
L. S. London, M. D. "A Study in Depersonalization" (1939)

E. *War Psychiatry*

Ralph S. Banay, M. D. "Psychiatric Aspects of Wartime Delinquency" (1943)
Harry Benjamin, M. D. "Morals vs. Morale (The Sex Problem in the Armed Forces)" (1943)

Kurt Goldstein, M. D. "So-Called War Neuroses" (1943)
Benzion Liber, M. D. "The Psychiatric Patient and His Induction into the Army" (1942)

F. *Social Psychiatry*

Frank S. Caprio, M. D. "The Psychotherapeutic Challenge of the Compensation Neurosis" (1939)
Wladimir Eliasberg, M. D. "Medical Sociology and Propaganda" (1942)
Arthur N. Foxe, M. D. "The Massive Structure of Delinquency" (1942)
Eric From, Ph. D. "Psychoanalysis and Sociology" (1940)

G. *Commemorative Sessions*

L. S. London, M. D. "In Memoriam Dr. Sigmund Freud" (1939)
Emil A. Gutheil, M D. "William Stekel's Contribution to Psychotherapy" (1940)
Clara Thompson, M. D. "Ferenczi's Contribution to Psychoanalysis" (1944)

FORUM DISCUSSIONS

A. "*Recent Advancements in the Psychotherapy of the Child*" (1943)

1. "*Juvenile Delinquency and Psychotherapy*"
   Speakers: Justice Jacob Panken; Marjorie Bell; Wladimir Eliasberg, M. D., Frederic Wertham, M. D. *et al.*
2. "*Children's Reaction to the War and Its Psychotherapy*"
   Speakers: J. Louise Despert, M. D.; Katherine Woodward, M. D.; Helen Papanek, Ph. D.; Marie H. Mercier, M. D.; *et al.*
3. "*Adolescents in Need of Psychotherapy*"
   Speakers: E. Dalton Partridge; Theodora Abel, *et al.*
4. "*Mental Hygiene in School and Psychotherapy*"
   Speakers: Alice Crow; Lester Crow; *et al.*
5. "*The Nutritional Basis of Mental Disorders in Children*"
   Speakers: I. Newton Kugelmass, M. D.; Joseph Wilder, M. D., *et al.*
6. *Clinical Psychotherapy of the Child*"
   Speakers: Bernard L. Pacella, M. D.; Lewis R. Wolberg, M. D., *et al.*
7. "*Preschool Education and Psychotherapy*"
   Speakers: Mary S. Fisher; Cornelia Goldsmith; Benjamin Spock, M. D.; Margaret Wagner, Dean, Ann Reno Institute; Louise P. Woodcock, Bank Street Schools, *et al.*
8. "*The Role of the Family in the Psychotherapy of the Child*"
   Speakers: Marynia Farnham, M. D.; Leo Kanner, M. D.
9. "*Adult Psychotherapy and Child Psychotherapy*"
   Speakers: C. Bellinger, M. D.; Frederic J. Farnell, M. D.; Janet Rioch, M.D.

B. "*Present Needs for Advancement in the Health Care of Children* (1944)
(In Conjunction with the Ann Reno Institute of New York City).

1. "*Mental Hygiene—And Mental Health Care of Children*"
Speaker: J. Louise Despert, M. D.
2. "*Therapeutic Considerations in the Prevention of Juvenile Delinquency*"
Speaker: Herbert D. Williams, M. D., Superintendent, N. Y. State Training School for Boys.
3. "*How Institutions Assist in the Mental Health Care of Children*"
Speaker: Lewis R. Wolberg, M. D., Director of the Children's Ward, Kings Park State Hospital.
4. "*Child Labor Problems and Mental Health Care of Children*"
Speaker: Gertrude Folks Zimand, General Secretary of National Child Labor Committee.

SEMINARS

1940-1944, *Spring and Fall Seasons*:

"*Practice of Active Analysis,*" by Emil A. Gutheil, M. D.
"*Disorders of the Autonomic Nervous System and Psychotherapy,*" by Joseph Wilder, M. D.
"*Group Psychotherapy,*" (Psychodrama) by J. L. Moreno, M. D.
"*Expermental Basis of Psychotherapy,*" by Otto Loewenstein, M. D.
"*Clinical Psychotherapy,*" by Wladimir Eliasberg, M. D.
"*Gynecology and Psychotherapy,*" by Fritz Wengraf, M. D.
"*Endocrinology*" by William Wolf, M. D.
"*Abnormal Traits in Normal Children,*" by Ernest Harms, Ph. D.
"*New Methods in Analysis, Testing and Evaluation of Personality,*" by P. Lionel Goitein, M. D.

SYMPOSIA

1. "*Religion and Psychotherapy*" (1943), with the speakers: Rev. James H. Griffin (Catholic); Rev. Seward Hiltner (Protestant); Dr. Sidney E. Goldstein (Jewish); Hans Robicsek, M. D.; and E. A. Gutheil, M. D.
2. "*Juvenile Delinquency and Its Treatment*" (1943), with the speakers: Justice Hubert T. Delany; Lionel Goitein, M. D.; Daniel E. Schneider, M. D.; and Ernest Jolowicz, M. D.

Abstracts From Current Literature

A - Psychoanalysis

LOVE AND ANGER. IZETTE DEFOREST. *Psychiatry*. 7:15-29, February 1944.

Freud established a chart of the development of human personality. He indicated how it can be wrecked and mentioned the types of disaster to expect. He taught not only the psychological laws of human behavior, but also the methods of guarding against accidents to human personality and the means of repairing any damage. He indicated the vast emotional realm underlying the physical and mental systems where love and hate and other related emotions are blocked or released in the stress and strain of life. Knowledge of these emotions has increased. Their sources are now labeled and recognized. There has been developed a larger knowledge of these forces from a descriptive point of view.

The methodology of psycho-analytic treatment is well known, but the reason for the success of this methodology and their activating principles have been little studied. The purpose of this paper is to offer some suggestions as to the dynamism of the psychoanalytic process. Love and anger are the intrisic fundamental emotions. The conflict between these two forces and their appropriate modifications is the base on which human beings form their characters. Happy and successful people originate from a persistent victory of love over anger. While this seems a trite truism, there is less willingness to consider unhappiness, maladjustment and failure as a consequence of the conquest of loving nature in human beings by the ferocity of their hatred. Assuming this to be true, one may see that in all neuroses, and perhaps in all illness, the diagnostician is confronted wth the results of a raging but unconscious struggle between these two emotions and in a partial success of the destructive forces. The therapeutic treatment necessarily becomes a continuance of this struggle with an aim of change in the outcome. Neurotic illness includes unhappiness and a sense of impotence and failure, whether it is found in hysterical symptoms, in obsessions and compulsions, in behavior problem or in defects in character.

In the analytic process there is a constant change in emotional content, quality and emphasis because of the varying elements in the relationship of the patient to the analyst. Three stages are discernible: "in making the acquaintance of the figure and personality of the analyst, the patient gradually rids himself of his defenses, begins to sense strongly his repressed hostility and to become dimly aware of his feelings; in taking account of, and struggling with, this personality, which has for the moment become the center of his life, the patient dares to give vent to his hateful impulses; and, in resolving this struggle, the patient, increasingly freed from anxiety, gains the courage to release his loving and creative impulses as well as to make constructive use of his anger."

Three cases of treated neuroses under these three separate stages of interrelationship between analyst and patient conclude the article.

Chester D. Owens,

Woodbourne, N. Y.

B - Neuropsychiatry

FORMULATION OF PSYCHOPATHIC PERSONALITY. ROBERT M. LINDNER. *Psychiatry*, 7: 59-63, February, 1944.

Psychopathic personality is a behavior disorder exhibited especially in social life and characterized by the inability of the individual to engage in satisfactory social relations and activities. This condition is based upon some predisposing factors in individual biology (heredity and physiology) activitated by situations, conflicts, and frustrations of early life. Thus, psychopathic personality must be viewed in the culture in which it appears. What is symptomatic of psychopathy in one culture may not be in another. Psychopathic personality belongs among the compulsive disorders. The subject behaves in a restraint-free manner subject to the impelling drives and motives of the particular moment. The phylogenetically more recent and higher centers of the brain are structurally defective or injured. Ordinary inhibition of activity is lacking and the personality is swayed by moods, whims, and fancies. Immediate needs and desires are satisfied on an infantile level.

The symptomatology of the psychopath varies from culture to culture and from individual to individual, however, a general pattern may be observed. The symptoms may appear in varying degrees, therefore, differential diagnosis is necessary. The following broad symptomatic constellations are to be considered: defective relationship with the community, inability to pursue socially acceptable goals, rejection of constituted authority, maladjustment and perversion in the sexual sphere, overt aggression demonstrated especially in the social field, lack of appropriate emotional responses, almost total lack of insight with regard to the self, defective judgment as evidenced by marked imbalance between ego and social goals, verbal rather than emotional acceptance of social precepts, intelligence in the range of normal to superior, strong migratory tendencies, marked egocentricity, and, quick ability for rationalization.

A listing is also given of other symptoms which may appear or be derived from the foregoing. There is also a listing of features of the developmental history which aid in establishing the diagnosis. The psychological symptoms are so varied that it is practically certain several causes are involved. At the present state of knowledge it is too premature to advance categoric statements with regard to the etiology of the psychopathic personality. Research and the literature point to several directions. Since psychopathic behavior is a chronic type of reaction expressed in primitive reactions it suggests cortical involvement and the malfunctioning of those higher centers which maintain control over the lower ones which reconcile the more basic motives and drives. Further evidence for the assumption of fundamental physical differences appear in the casual observation that these personalities preserve youthful appearance, firm musculature, trim bodily build, absence of middleage signs such as greying hair and in other studies which show that senility in psychopaths is a rarity.

Five types of psychopathic personality emerge: sexual, paranoid, criminal, uncomplicated, and, those with the symptoms but who do not fail in either of the former.

The application of an adequate program of rehabilitation for the treatment and training of psychopathic personalities can be done readily in a prison for the penal population having a large number of these personalities. The Federal and many state systems are convinced that a special treatment of these prisoners is a definite responsibility. Without this treatment they will not adapt either within or without the institution. Perhaps within a reasonable length of time objective procedures, tests, personality screening scales and other aids will be available.

Chester D. Owens,

Woodbourne, N. Y.

A Study of Women Psychopathic Personalities Requiring Hospitalization. Robert J. Van Amberg. *Psychiatric Quarterly*, 18:61-77, January, 1944.

Some of the difficulties in defining the term "Psychopathic Personality" are touched upon by the author who suggests that perhaps confusion in part may be due to the fact that this term can be used in both a positive and negative direction. The positive tendencies might appear as overt behavior; that is to say, a dynamic manifestation of lack of adaptability. In a negative sense, the individual's characteristics may be below par inasmuch as he may be emotionally unstable, inadequate in meeting situations and, in general, an undependable sort of person. Of the various classifications proposed by students in the field, the author feels that that which approaches the subject from the viewpoint of the outstanding behavior aberration presents a better evaluation than those which depend upon symptomatology. In his study of a series of thirty-four women classified as Psychopathic Personality by the staff of the Westchester Division of the New York Hospital for the period 1931 to 1940, the author has treated the subject under four groupings:

Group 1: The anti-social psychopathic personality (5 cases).

Group 2: The overly indulged pspchopathic personality (15 cases).

Group 3: The almost-adequate psychopathic personality (5 cases).

Group 4: The sexual psychopathic personality (9 cases).

Group 1 comprises by all means the largest class of psychopaths that is ordinarily encountered by the psychiatric practitioner. The makeup of these individuals is very well known. They are undisciplined from childhood and behave throughout their life in a selfish, dominant assertive fashion. They must be the center of all activities, expect to be humored, deferred to and will brook no interference in their plans. In many instances they are of high degree of intelligence, even charming in their manners when things are going well with them but exceedingly ugly when frustrated. As long as their youthfulness, good appearance and charm are attractive to others, they may succeed in securing the attention and deference they crave but when these attributes fade in later life, they become exceedingly difficult people with whom to deal. An increasing number of conflicts with others and friction with the demands of everyday life arise and it is then that all sorts of psychosomatic complaints and neuroses are added upon a constitutional psychopathic makeup. Such individuals have no difficulty in getting married but, of course, seek marriage as a convenience and not as a project which is to be shared with someone else. The failure to adjust to the requiremnts of the marital state may lead individuals to seek all sorts of abnormal outlets, such as perversions, sexual excesses, and homosexuality. If children are born to them, they are inclined to reject them. Their whole attitude toward the community is anti-social. Ther is no well-formed purpose in life nor any drive to atain an anticipated goal.

The second group is in marked contrast with Group 1 inasmuch as these individuals are not anti-social but through their willingness to conform, get good rapport with other people. They pursue a social life throughout because they are in dire need of support. They often make good wives inasmuch as there is an outstanding need for dependency upon their husbands. There is no conflict about the demands of the marital state. Children are accepted willingly and homelife on the whole is likely to be quite adequate. However, without the help of others they are very likely, particularly as they enter adulthood, to find themselves quite inadequate to meet the economic demands of life.They have not the force of character to pursue anticipated goals. They have an inability to assume responsibility and they have learned to such an extent in early life to depend upon the goodwill of others that when this prop is withdrawn from them, they do not have sufficient firmness to meet the situation themselves. Marriage in many instances is the solution to their problem. In the event that such a solution is not found, the individual goes along feeling frustrated and becomes subject to emotional outbursts against situations which would not affect the ordinary individual. Thus, a mild paranoid attitude toward the

world in general is maintained. Frequently there is rebellion against the family.

The 3rd group has the same emotional turmoils and paranoid trends and the same rebellious attitude as Group 2. However, these are not quite so much in evidence and the individuals succeed in childhood and adolescence in making normal adjustments. Occasionally here and there will be an incident which is a clue to an underlying personality defect but if no great stress is thrown upon the individual, she may be considered for all practical purposes as normal. There is, however, a character defect which manifests itself in a tendency to limit their associations with other people and to have no well-defined nor developed interests. They seem content merely to live without a definite objective.

The fourth group dealing with the sexual psychopathic personality is in many ways the most dramatic and interesting of the groups. The underlying essential difficulty is that of homosexuality which may or may not be recognized by the individual and in some instances cannot be accepted and faced. The individual many times is of high intelligence, charming personality and very effective in social contacts. Much of this are surface phenomena as the individual does not have the innate ability to merge her life with that of someone else. The net result, of course, is that she cannot consummate a successful marriage. Marital relationships are entered into with a definite promise of happiness but after a time there is a failure to secure harmonious adjustment and the result is that the individual turns either to excessive sex behavior, usually accompanied by drinking, or a total rejection of the sexual life entirely. These rejected states, of course, lead to such abnormal behavior as excessive masturbation, perversions and, in some cases, frank acceptance of homosexual acts. Many of these patients become very successful in business and especially are likely to have artistic talents of no small order. The group rejects the husband and their own parents. Often the parents are blamed for their difficulties. In early life, however, there is usually a strong emotional attachment to one of the parents with rejection of the other. This attachment does not assume the proportions, however, of a fixation.

V. C. B.

PSYCHOPATHIC BEHAVIOR, FOXE, A. N., *American Journal of Orthopsychiatry*, 14:308, 1944.

Masquerading as normal individuals in society are certain infantile characters, plausible, engaging, even intelligent, that show something of the psychiatric stamp that the author has designated "inadequate, anti-social, primitive nomadic liars." These represent traits of a psychopathy, that is an unconscious artifice of being, "a prop rather than a truly solid structure." Placed in a position making some demands (as in public speaking) the average person may prepare for it or get by on his own resources, or offer a plausible excuse. Not so the psychopath. He becomes unnecessarily evasive, may develop neurosis or a fashionable somatic ill, imagine his prestige is at stake or overvaluate his success, Jack Horner wise, if he does scrape through. This is more likely to appear under conditions of isolation (incarceration) taking the form of a "facade neurosis" from internal adaptations or "over desire to please" in each instance adapting to a false world. Such intense problems peculiar to institution life may favor psychopathy which would be psychosis on the outside.

Most of the tribe of young persons living by their wits, creating masquerades out of the common-place, and facades to deceive the world follow essentially false goals. They are pretentious, ambitious (if it cost them little), ingratiating and finally tyrranical, when the wrong job finds out their inadequacy, and they must needs fill in their empty understructure. Theirs is a socially wasted talent; they pit their wits against real experience and suffer disillusion sooner or late; their deceiving is unconscious. They often come from quite good families, whose false goals, ambitions and flatteries are their undoing. Of such pretentiousness the world is the real judge. They never develop insight and shun psychiatric help, till deflation sets in; they run

away from themselves. In their cynical devaluation of others, piercing other's masks, while blind to their own; they show the deep character ingrain of their madness.

This is an age of psychopathy in society, but the criminotic shows its sickness best behaving like a false warrior in the war of life, accepting fatalizing force, making "guilt a yoke around the warriors neck." Environment is blamed for fixing his delusion, his patterns of apparent success; he can only see his brilliance when the rest of the world can only see his crime. He cannot accept the naked truth in regard to himself; he eschews psychologic help, eluding it till in extremis (deflation of ego). He thrives more on human gullibility, which feeds his pride; life thus becomes "a split shift" for masquerades of borrowed plumes; while "all the world becomes a stage" for the emergence of a special personality. Life itself seems haphazard. He is tried in the sifting processes of society and fate, like guilt, eventually draws the delinquent down. Because he is obsessive he aims too high and works his way down. He has no staying power, no basis for real events and demands.

P. L. Goitein,
Woodbourne, N. Y.

C - Clinical Psychology

THE CONCEPT OF NORMALITY IN CLINICAL PSYCHOLOGY. JOHN W. THIBAUT. *Psychological Review*, 50, 338-345, May, 1943.

The author takes issue with the prevailing psychiatric usage of the term "normal" which identifies it with the social reaction-average. The definitions of Hinsie and Schatzky, Kraines, and others are cited as examples of the concept of normality which is now current in psychiatry and which regards the "normal as the average or the mean of a normally distributed population and thus a measure of the degree of conformity of the individual to his particular culture."

One of the criticisms of the current concepts of normality involves the fact that in accepting a relativistic norm, psychiatry isolates itself from its culture. Strictly, the clinician must find all cultures incommensurate, and the population of his own culture, regardless of its 'values,' a normal standard grey. Thus, moral and aesthetic norms may as well reside in another galaxy, for they are provided no room in the psychiatric universe, except in so far as their professors constitute the clinical subject matter. The basis for the difficulty is that the psychiatrist's norm is wholly inadequate as a means for achieving a unified intellectual attitude. In accepting an 'adjustment' concept of normality, the clinician is required to regard 'mental health' as something distinct from "physical health" and thus, implicitly, to perpetuate the mind-body dichotomy. As an example, no physician would seriously assert that a man is healthy simply because he conforms to the specifications of a social reaction-average.

There are also internal difficulties in the formation of a psychiatric norm. In some cases it is possible to find 'abnormalities' which occur on a mass basis. The obsessive behavior of Puritan witchcraft and witch-burning pervaded a whole culture. According to the psychiatric position the 'abnormality' presumably disappeared with its general adoption by the community. As an example of internal difficulties, the author cites Glover's description of the "normal psychoses and normal neuroses of childhood" as occurring almost universally among children. This would seem to mean either that psychoses are not necessarily disease-entities, or that, once established as *universally present syndromes*, they are no longer psychoses, or that 'normal' and 'abnormal' do not in fact have any consistent meanings. There is thus a deep ambiguity which has never been satisfactorily cleared up.

The present paper further suggests that the psychiatrc norm lacks validation. Assuming that abnormalities may in fact occur on a mass basis, it is quite possible that, by intra-specific competition, the 'normal' man may destroy himself. There

is nothing in the basic psychiatric position which would prevent racial suicide from being perfectly 'normal.' This consideration exhibits a crucial lack of formal justification for the psychiatric norm. Validation of any fundamental concept demands sufficient provision for the persistence of its subject-matter, in this case man as phylum.

Many cultures are for one reason or another so manifestly 'valueless' and 'unwholesome' that, in spite of second-order repercussive efforts, the sensitive individual who rebels from the prevailing mores and so achieves a certain 'psychic distance' from his culture, is in many respects more normal and 'adequate' than his conformist contemporaries.

For all these reasons, the author urges that a new concept of normality be formulated: one that will do justice to the 'adequate' responses of dissenting individuals. He considers that Dr. Trigant Burrow's suggestion for the adoption of an objective norm based on phyle-biological requirements meets some of his objections to current concepts of normality. A *phylobiological norm* affords the possibility of specifiying the conditions under which the maximum phyletic homeostasis will obtain. "It is the phyloanalytic position that no behavior adaptation within the single individual can be healthy and complete in the absence of a healthy basis of behavior adjustment within the community as a whole. The therapeutic attempt, therefore, is not merely to heal the individual but to develop a healthy community basis of behavior that will be effective throughout the organization of man as a phylum."

Thus, instead of merely 'adjusting' a non-conforming individual to any culture he happens to be in, there will be a shift in emphasis to the revision of the culture as a whole. Psychiatry must adopt this fundamental change in its concept of normality if it is to become adequate to its tasks. It seems that the author would thus expect the psychiatrist and other social scientists to suggest cultural modifications based upon careful analyses of inadequate responses to the present culture and that these would be experimentally validated or invalidated by the process of history.

Samuel B. Kutash,
Woodbourne, N. Y.

SOME ASPECTS OF THE PSYCHOLOGY OF THE OFFENDER. JOHN M. MCGINNIS. *Federal Probation*, 8: 20-29, January-March 1944.

An analyss of current views in psychology, genetics, and psychiatry, leads the author of this paper to point out the importance of individual differences and to stress the fact that, for practical purposes, it is more important to pay attention to ways in which individuals differ from one another rather than to their similarities. Recent psychological investigations fail to find any evidence of a "criminal type" but, on the contrary, support the view that no two individuals are exactly alike.

Various aspects of recent psychological research in the criminal field are reviewed and certain trends noted. Feeblemindedness is no longer considered one of the major causes of crime. While there have been wide variations from study to study, there has been a consistent tendency for judgments of the amount of feeblemindedness in the criminal population to decrease. This trend is clearly shown in the recent investigations of Sutherland, Murchison, Kanner, and Gill.

The latest findings support the view that the great majority of offenders are at least of dull-normal intelligence and the highest delinquency rate is found in the dull group, rather than the feebleminded. Within an institution, the feebleminded behave as well as the non-feebleminded and there is no close relationship between degree of intelligence and success of parole.

Dr. McGinnis attributes the new findings, in part, to limitations of adult intelligence testing which have existed in the past. In reviewing these limitations, he points out that the tests most widely used in clinical studies such as the Stanford-Binet, Kuhlman-Binet, and others were designed for use with children and have limited applicability when used with adults.

Also, I. Q.'s based on different tests do not necessarily have the same meaning. On the old Stanford-Binet some investigators have calculated I. Q.'s using 16 as the denominator, while others have used 14 or 15. Many psychologists question the fundamental value of the I. Q. concept when applied to individuals over 13 or 14 years of age. A further limitation is the fact that older adults do less well on intelligence tests than younger adults and thus adult norms, corrected to fit the age of the adult subjects, are necessary for correct interpretation of test results of adults. Then too, the groups of offenders tested are not always representative samples of the offender population as a whole. Finally, offenders are not always motivated to do their best especially in those studies employing group tests. Some of the difficulties which have caused confusion and error in the past can be obviated by the use of tests especially designed for adults, such as the Wechsler-Bellevue Adult Intelligence Scale and the expression of test results in terms of standard scores or percentile scores of the age group rather than in mental age or I. Q. of the subject tested.

It is on the more subtle aspects of the individual's emotional life that the emphasis is being placed in modern studies of the psychology of the offender. The Gluecks in their thorough statistical follow-up of the careers of 500 offenders, found marked differences between reformed and non-reformed offenders in percentages revealing mental abnormalities such as mental disease, distorted personality, or excessive instability. Those offenders who were mental deviates tended to continue their criminal careers longer and to be less adjusted to normal society. Healy and Bronner's results as reported in their book "New Light on Delinquency and its Treatment" bears out the Gluecks' findings. These authors report that their studies fully corroborate "the modern conception of the emotional life as the great dynamic force and of emotional experiences as the most significant conditioning factor in the production of behavior tendencies." They too found that emotional rejections, feelings of inadequacy, jealousy, mental conflict, and unhappiness about family disharmonies were frequently involved in the cases studied by them.

Dr. McGinnis discusses the concepts of *deprivation and frustration* of Maslow and Mittelman, of *frustration tolerance* of Rosenzweig, and of the relation between frustration and aggressiveness brought out by Dollard and his collaborators. He believes these concepts to be valuable in understanding some of the differences between delinquents and their non-delinquent controls, studied by Healy and Bronner,, and some of the differences between the reformed and recidivist offenders studied by the Gluecks.

The author concludes that the modern trend in psychology as it applies to the offender is to stress not low intelligence nor the gross physical, economic, or social circumstances of the offender's life, but such emotional factors as: feelings of security or its lack; desire for personal recognition, affection, and attention; feelings of rejection, inadequacy, or jealousy; unhappiness about family problems; and other sources of mental conflict.

Samuel B. Kutash,
Woodbourne, N. Y.

PERSONALITY STRUCTURE AND PROGNOSIS OF ALCOHOL ADDICTION: A RORSCHACH STUDY. OTTO BILLIG AND D. J. SULLIVAN. *Quarterly Journal of Studies on Alcohol.* 3: 554-574, March 1943.

The authors made a Rorschach study of 40 chronic alcoholics of varied education and cultural background. They point out that no previous studies of the personality of chronic alcoholics on the basis of the Rorschach technique had been made with the exception of one short discussion on 10 cases by Jastak and another by Weber. The patients of the present study were divided into four groups. Group I contained only those patients who had been admitted for the first time for the treatment of chronic alcoholism to any hospital and who had not been drinking since their discharge. The patients in Group II

were those who resumed drinking since their discharge but whose drinking had not interfered with their activities and who have been able to carry on with their regular work, which they were not able to do prior to their present hospitalization. Group III consisted of those patients who started drinking soon after their discharge and have not been able to resume their regular work and are not capable of caring for themselves. Group IV was made up of subjects who could not be observed during a follow-up period but who can be considered generally as having a very unfavorable prognosis. The entire series included 34 men and 6 women, ranging in age from 22 to 62 years.

A chart is presented giving the individual findings in the tests of the 40 subjects and another presents the ratios of the basic personality configuration. Previous clinical descriptions led the authors to expect that tension within the personality structure would be an outstanding factor in the chronic drinker. The cases were summarized, using Klopfer's relation of VIII plus IX plus X over R to (FM plus m): (Fc plus c plus C minus) and to M: sum C as an expression of the basic personality configuration. Of these, VIII plus IX plus X over R is the most reliable and more basic factor, while (FM plus m): (Fc plus c plus C minus) shows a balance involving factors dealing with the more "primitive layers of the personality" and early fixations. Rorschach's original *Erlebnistypus*, M: sum C, indicates the actual adaptation of the individual, being the most susceptible of the three factors. A distortion within these three factors would express tension within the different levels of the personality organization.

Of the 40 cases studied, 38 (95 per cent) showed distortion in the interrelation of the 3 factors.

The basic personality configuration, as indicated by the ratio VIII plus IX plus X over R per cent, shows primary extroversion in Group I (the prognostically most favorable group) and a definite reduction of extroverted tendencies in Groups III and IV. This would suggest that the patients in the prognostically favorable group are primarily more capable of copying with objective reality than the other patients.

Regardless of the prognosis, 65% of all subjects apparently attempt to withdraw from their usual environment (FM plus m larger than Fc plus c plus C minus), a factor well known in the problem drinker.

The ratio indicating the actual adaptation to the inner and outer environments (Rorschach's *Erlebnistypus* — M: sum C) shows more frequently manifested introversion among the subjects in Group I.

Certain other conclusions of the authors are significant. The increased W% leads them to expect that the alcoholic's ambitions are rather high but the actual achievements are limited (W plus : M). The small W plus % over W, particularly evident in the subjects with a poor prognosis, indicates the patient's resistance toward the attempt of the therapist to penetrate the complex mechanism and is, in the authors' opinion, of high prognostic significance.

Only a few of the subjects (12.5 per cent) show FK. This small percentage is in accordance with the experience that this factor indicates the ability of the individual to "smooth out the relationship between reality and his own self," an ability rarely found in alcoholic addicts.

In the alcoholic addicts with a poor prognosis, an increased number of factors indicating aggressive and primitive tendencies can be observed. This is seen particularly in Group IV, a group in which we expect less restraint in the expression of such thoughts. The reduced A% found in a good many subjects indicates a rich imagination which is used, however, to satisfy their primitive and self-centered wishes.

The authors conclude by emphasizing that in their opinion these test results do not represent the actual prognosis but merely show the ability to respond to treatment. With properly directed treatment and in proper surroundings a less promising patient might adjust himself better than some other patients, or vice versa.

S. B. Kutash,

Woodbourne, N. Y.

ON THE MEANING OF INTELLIGENCE. GEORGE D. STODDARD. *Psychological Review*, 48: 250-261, May 1941.

After reviewing what he considers to be the inadequacies of existing definitions of intelligence and pointing out the need for a new type of definition which could be used as a basis for the construction of more adequate intelligence tests, Dr. Stoddard brings together what impresses him as the principal attributes of a functional concept of intelligence.

The origin of the Binet method of intelligence measurement in response to the practical demands for the early discovery of children likely to fail in school meant that theory was kept to a minimum. The tests were constructed around the simple principle that a large number of graded small tasks, each involving the higher thought processes, would approach a concept of *general mental ability*. The expression of this general mental ability in the form of an I. Q. brought with it the illusion that we now had something fixed and mathematical like the measures and pointer readings of the mathematicians and physicists. The considerations given weight in the selection of test items did not throw much light on the meaning of intelligence. Mental ages are not equally meaningful or comparable for people of differing chronological ages and the I. Q. is not constant for any individual.

As a result of the direction taken in the development of practical mental testing, the meaning of intelligence, especially as it emerges from all child testing of the Binet type, is *scholastic aptitude*. The same conditions that lead to poor school work may yield low I. Q.'s; in fact, there is thus far no higher validity for mental testing than its tendency to parallel school achievement.

The author states that in order to undertake the measurement of intelligence, it would first be necessary to define the term and then set up the necessary operations and test procedures rather than vice versa. Mild steps in this direction have been taken in Spearman's principle of the eduction of relations and Wechsler's recent work on the Bellevue Intelligence Tests. Before you measure, you must know what you are looking for.

Dr. Stoddard's own definition, while its separate portions are not original, is new as a composite and is based upon qualities rather than factors, components, or special abilities. He defines *intelligence* as the ability to undertake activities that are characterized by (1) difficulty, (2) complexity, (3) abstractness, (4) economy, (5) adaptiveness to a goal, (6) social values, and (7) the emergence of originals, and to maintain such activities under conditions that demand a concentration of energy and a resistance to emotional forces. He then defines each of the seven terms in his definition. For example, *difficulty* is a function of the percentage passing and throughout a series of measurements, it must increase with chronological age, so long as we postulate mental growth. *Abstractness* is a means of connecting ability to symbolic relationships, etc. The definition is further elucidated by pointing out its applications in various fields in which intelligence presumably functions.

The form of testing required to measure intelligence, as defined in this paper, is briefly discussed. The new tests must give scope to originality, style and invention. They must provide for more than a verbal medium of intellectual expression; for example, they should employ space relations, performance tasks, and scientific symbols. More learning-on-the-spot types of performances would appear helpful, with less emphasis on what the child already has learned and is now bringing to the test situation.

Concerning the nature-and-nurture problem in relation to his definition of intelligence the author believes that intelligence as a system of behavioral manifestations, is culturally determined. Such depressants as physical exhaustion, illiteracy and other cultural impoverishments, together with the profound effects of taboos, traditions, and emotional blockings, may serve effectively to retard what we call normal mental growth. Still, organic defects and differences do exist and some, but certainly not all, are carried down in genetic lines which no guidance or favoring can bring to normality.

Samuel B. Kutash,
Woodbourne, N. Y.

D - Anthropology & Sociology

CRIME CAUSATION—A SOCIOLOGIST'S VIEWPOINT. WILLIAM E. COLE. *Federal Probation* 8:18-21, April-June 1944.

It is difficult to find the causes of social phenomena, especially crime. There is a multiplicity of factors in the nature of such social problems as war, crime, desertion, poverty, and dependency. The sociologist does not emphasize "the relationship between certain social conditions or forces and criminal behavior" so much as he prefers to use the term "causative factors" rather than "causes."

Early in the history of our county we acquired a social tradition for law violation. We protested against the British and dumped their tea, on the other hand we swindled the Indians. We, thus, early learned to select laws to which we would conform. Conditions of like calibre exist in our country for we have areas where the frontier attitude toward laws prevail. Our high crime rate can not be excused on the basis of "our frontier individualism." Canada's crime rate is lower, perhaps because of her speed in administering justice. The delay which exists in this country encourages crime. In addition, unholy alliances between law-enforcement officers and politicians and legal protectors of criminals nullify the effectiveness of the law and the machinery of justice. Just recently the legal profession has realized the necessity of clearing its ranks of its illegal practioners and creating in the mind of the public an attitude of respect for the profession. This trend toward higher standards should improve the administration of justice and there cut down one of major encouragements of organized crime.

Our society is materialistic; our standard of living the highest in the world. Business is big, therefore, crime is big. Our culture is diverse and its character dynamic rather than static. A highly heterogeneous population will have a greater crime rate than a homogenous one. The city will contribute more to the volume of crime than the country. Social controls of home, church, kinship groups, and other primary relationships and institutions are strong in the country. The social isolation of individuals in urban communities, the weakening hold of primary controls on individuals, the constant parade of a high standard of living on one hand and demoralizing poverty on the other, indicate why cities contribute more to crime.

The basic social unit is the family. The time children spend in it, the prestige of parents, the repetition of events and attitudes, and the vividness of experiences in the family indicate why it is the most important social unit for influencing the young. The nature of the conditioning process in the family will determine to no small degree if the individual is to become delinquent or not. Economic insecurity of families with attendant evils of frustration, poor housing, working mothers, out-of-home temptations, inadequate diets, inadequate home supervision, and generally low standards of living all meet in the home or community to furnish the environment and social condition conducive to delinquent behavior. Evidence is beginning to show that undernourished children who are subjected to corrected diets improve in their orderliness in social relationships in play.

The author also discusses "Jails and Crime" and "Intelligence and Crime" giving the social factors involved in both. In conclusion, he points out that the "theory of individual responsibility for crime is waning while social causation and social irresponsibility appear as the most important causative elements in criminality. Few people born today would be criminals tomorrow if their family life, their community life, and their institutional life were happy and effective."

Chester D. Owens,
Woodbourne N. Y.

E - Social & Statistics

THE NEUROTIC CONSTITUTION — A STATISTICAL STUDY OF 2000 NEUROTIC SOLDIERS. ELIOT SLATER. *The Journal of Neurology and Psychiatry* — London. (New Series) 6:1-16, No. 1 and 2, January and April 1943.

The approach to the analysis of the neurotic constitution made by the author has been a purely statistical one which the sub-title clearly indicates. The interpretation of the statistics, however, which covers the study of some 2000 disabled veterans in the British Service has been made with the clear understanding of the limitations of the statistical method. The author realizes that there should be no biased samplings, no distortion of the results to prove a certain idea on the part of the author, and there should be sufficient data of a certain uniformity as to warrant the collective use of the statistics. The author believes that only to a certain extent does his material fulfill these requirements. Nevertheless significant trends can be determined to warrant the employment of the statistical method. Throughout the article statistical tables havae been employed freely but have been discussed with an unusual degree of penetration as to the significance of the results. A diagnostic schema is offered which includes the equating of such pathological states as hysterias, endogenous states and reactive depressives with the better-known and more clearly-cut entities of organic syndromes, psychopathic personality, anxiety neurosis and epilepsy. The appearance of large numbers of these cases among the disabled veterans probably justifies such an equation. In ordinary practice one would hesitate in giving the hysterics and reactive depressives an undue prominence. The author's remarks concernng the prevalence of specific trends among these groups may be outlined as follows:

1. *Organic cases*, as well as epileptics and mental defectives tend to approach in their symptomatology, the makeup of the normal soldier more closely than the other groups in the schema. The deviations from normality in these groups are inclined to have specific trends of their own. For example, organic cases frequently have well-defined focal symptoms as a result of limited damage to specific areas of nerve tissue.

2. The *Mental Defectives* showed an increased liability to hysteria and in common with the psychopathic personality, a generally impoverished sexual life.

3. The *Schizophrenics* obviously have strong paranoid trends and unsocial traits but seem to be relatively immune to hysteria and anxiety.

4. The *Anxiety Group* is free from hysteria but has stormy periods which are directly associated with events in the environment. These are of short duration.

5. The *Hysterics* show marked obsessional traits and instability of mood. When they are ill, they tend toward hypochondriasis and somatic fixations.

6. *Psychopathic Personalities* show a marked sensitization to reactions to stress of every kind of abnormal manifestations. They are in a "trigger-like" state for sharp reactions to situations which would be ignored by the average individual.

7. The *Endogenous States* are relatively free from hysteria and mental defect but are susceptible to obsessional traits. More than 50% of them show the pyknic body type. Childhood neuroses are rare with this group. The endogenous states are not an intermediate between reactive depressions, anxieties and hysterics but line up with any of these states in accordance with the individual concerned.

8. *Reactive Depressives* show the general picture of endogenous states but are differentiated from them in having a marked tendency toward history of childhood neuroses and having no more than the average number of pyknics in their group.

The author is at some length to differentate these two conditions and says that the endogenous depressions are related closely to the manic depressive type of personality, whereas the reactive depressives include obsessional neurotics, enuretics, and malingerers. Other differential data are the relative unimportance of precipitating factors and refractoriness of the depression to influence by suggestion.

As would be expected. by far the largest percentage of veterans in these various groups was to be found among the anxiety neurotics. The runner-up, hysterics, were only half the number of anxety states.

With respect to the outcome, the author demonstrates that he is a constitutionalist and emphasizes that psychotherapy, though well-intentioned, is entirely secondary to hereditary factors. "It would seem that what a man is by heredity and constitution is much more decisive for his future than any trifling alterations that can be brought about in him by psychotherapy and mental and physical rehabilitation."

Some interesting deviations in the response to treatment are mentioned by the author. Conscientious objectors respond more readily to psychotherapy and will return more frequently to active military duty than other types. This seems to be due to their being fundamentally conscientious and, therefore, desirous of doing their duty. Home conditions such as worry over the economic state of the home, the possible infidelity of the wife, illness in the family, etc., are markedly important factors in retarding the recovery of these individuals. In general, those who have shown a neurotic childhood and those who have obsessive trends are much slower in recovering than others.

Perhaps the most illuminating portion of the article is the author's discussion of the structure of the neuroses. A table of six categories has been prepared covering the following groupings with tetrachoric correlation coefficients as indicated:

1, Obsessional:	$r = +0.76$
2. Hysterical:	$r = +0.51$
3. Paranoid:	$r = +0.50$
4. Anxious:	$r = +0.40$
5. Depressive:	$r = +0.39$
6. Hypochondriac:	$r = +0.19$

These findings indicate that among all symptoms the obsessions are most firmly rooted in specific predisposition; next, in order, hysterical and paranoid traits. While the importance of the constitutional make-up in anxiety and depressive groups cannot be gainsaid, this factor is considerably less important than the other types. The hypothesis presented by the author is that "a neurosis represents a specal case of a generalized type of behavior, and signifies a failure of adaptation". The factors of the interaction of individual constitution and environment constitute an interesting kaleidoscopic byplay which makes it difficult of evaluation in any given instance, but as has been stated in this review, the author tends strongly toward weighting the constitutional factors. The hypothecation of the neurotic constitution, as indicated above, has proved useful in evaluating the possibilities of rehabilitation of military casualties. Intelligence is almost wholly determined by genetic factors and if the same is true of the neurotic constitution as the author believes, then one may deduce that the opportunity for rehabilitating these men under military conditions is not particularly hopeful especially in the obsessive states.

V. C. B.

F-Medical & Biology

AUTONOMY IN ANXIETY. D. EWEN CAMERON. *Psychiatric Quarterly*, 18:52-60, January 1944.

The position that Dr. Cameron's work has come to occupy in the field of Psychiatry is well-known in his frequent communications and books. The discussion of a certain type of anxiety in the present article is in conformance, of course, with his usual thought with respect to the relationship of physiological process to mental phenomena. Dr. Cameron admits that the great proportion of anxiety states are based on a conflict situation in which the individual senses that his security is being threatened and, in addition, unexpected traumatic events may be experienced. This threat to the ego of the individual may assume catastrophic proportions inducing near panic states of an anxiety type. Dr. Cameron, however, feels that aside from this well-recognized syndrome, there is a residual group in whom none of the above factors can be found. He feels that in the present war situation, this group is relatively large inasmuch as there are a great many people who have been transported from the security of their usual homes to work under conditions involving hardship, lack of home comforts, often with members of the famly at distant points and, in addition, who must face highspeed work, the making of sudden decisions and the working under stresses which involve a tempo far beyond that to which they are usually accustomed. These stresses are adequately met by normal stable individuals but there is a certain type of individual who constitutionally is inclined to overact to a stressful condition. Individuals of such makeup are subject to many minor fluctuations which are not perceived by themselves. Some of them get mildly flustered upon entering a restaurant or meeting someone who seems to be of considerable importance, making purchases, speaking in public and in many other activities which are seemingly innocuous but from the point of view of summation, produce tensional states. These individuals also are usually conscientious, overly meticulous about details, worrisome, especially if events do not fall into their customary grooves and, in general, they get mildly perturbed if there is any disturbance in the regular routine of activities. Such individuals continue with their work but have an increasing mounting physiological tension which Dr. Cameron has indicated in a previous communication in 1943. It is induced by overactivity of the sympathetic nervous system with resulting increased muscular tonus. Previously Jacobson had shown that anxiety states were always accompanied by increased muscular tonus. Accompanying this, as Cameron has shown in some of his other studies, are such changes as fluctuating elevations of blood pressure, alterations in the respiratory rate with transient fleeting periods of anoxemia, increased discharges of adrenalin into the blood stream, fluctuations in the quantity of blood sugar. The sum substance of this contention is that Cameron and his followers equate anxiety states with physiological tension particularly of the musculature for this particular group of individuals. The question naturally arises as to whether these are true anxiety states and are to be classified as a sub-group of the so-called anxiety neuroses. In such a contention the author closely approaches the hypothesis that many mental phenomena can be explained on the grounds of disturbed physiologic states. Many students in the field of psychiatry are not yet ready to accept this contention.

The program of treatment for this group, as outlined by Dr. Cameron, seems sound and practical. He reduces the general tensional level by teaching the patient methods of relaxation and engages him in recreations which do not involve competition. He prevents the bringing forth of the anxiety response by having the patient gain insight as to the particular conditions which produce tension states, such as getting into arguments, being pushed into conditions of excitement, mingling with crowds, competition, being pushed with respect to the amount of work put out within a given time, etc. The "damping" of the tendency of the individual to react

with tension to a given situation is effectively accompanied by the use of mild sedatives in fractional doses. Veronal has proved to be especially valuable in 2½-grain doses two to four times daily.

V. C. B.

TENSION STATES IN THE NEUROSES. L. R. WOLBERG. *Psychiatric Quarterly* 17:685-694. October 1943.

"States" here means bodily states result of a complex hypothecated train of circumstances starting from biologic "needs". The inability of the neurotic to gain pleasure by the successful manipulation of his environment, throws sttress back on self in the form of restlessness and dissatisfaction. The world appears hostile, and against an imaginary world-view, elaborate and futile defences are built. Goal-diversion follows a besetting tyranny from within or by fear of loss of love from without. This derives from actual parent-rejection; an oceanic feeling of helplessness follows, that is reacted to according to type; e. g., with patterns of bullying, cringing, complacency, revolt, and the self drives (narcism, masochism, etc.). Such at best are but substitutes and subterfuges on which a flimsy neurotic world is constructed; the resultng character distortion necessarily isolates the individual from his real world.

Vicarious satisfactions arise, and unworthy behaviorisms like grandiosity of ideas or ambitions, or desire for power; the pursuits of life get neglected or appear uninspiring by contrast. The drive is the more compulsive as the patient gets subjectively oriented, till little apparent feeling is left for the basic excitements of life, such as sex and sleep. An *anhedonia* results from his internal contradictions. On the other hand, his (oral) demands on the world are often inordinate. Vicious circles are set-up through damming of inner tensions; and altered homeostasis and organic imbalance, like hemeostasis, follow, including electric disturbance. At this point Dr. Wolberg deserts the discussion of psychic tension for speculation on organic abnormal stimulations, and describes a tension state as a neurosis. Apparently "cortical penetrations . . . incite the ego" or "penetrate into awareness" to force it to adapt by conditioned techniques and patterns of behavior peculiar to itself, biologically necessitated even for animals.

Causative needs serve to repress the tension around the complexes and phantasies aroused, and further unrest follows. The patient seizes on daily rituals to explain it. He fears to acknowledge the cause of his tension (even if he knew) he rationalises his actions and his dreaming symbolises its purpose. Alleviation of the organic unrest is urgent; but "circuitous language associations" and survey of parapraxes (here miscalled psychoanalysis) will reveal it. Tension may not reach consciousness if it gets stopped by anxiety, and without psychic representations it goes begging till it spills over autonomically. The Ego system can thus be detrimental to physical health itself, from a "tension that constantly regenerates itself." The subject is only aware of the societal discomfort involved. No mention of ipsation occurs in all this.

Neurosis is next explained as inability to *produce* a set of substitutive pleasures for deprived ones, or a *system of inhibitions* to deal with frustrations. Mind has inadequate systems and higher sensitivity leads to fresh complaints; though some, of the martyr sort, derive pleasure from the suffering. It is from lowered threshholds to sensation that tension arises.

Fullest adjustments to life demands can only be secured by liberating the ego from its false goal, rescuing it from isolation from its own impulses. This is far better that *drowning* self in violent social or sublimatory outlets (work or sex), or a resort to alcohol. At all events tension is best relieved and kept mobile for biologic ends; ("tension at the visceral level"). Interpersonal relations will recanalise the needs and relieve the wasteful neurotic struts against stress. No mention of super-ego conflict is made in all this.

P. L. Goitein

THE ELECTROENCEPHALOGRAPH IN PSYCHOPATHIC PERSONALITY. JOHN R. KNOTT AND JACQUES S. GOTTLIEB. *Psychosomatic Medicine.* 5:139-142, April 1943.

The authors incline definitely toward the group of investigators who are inclined to find use for the EEG as a diagnostic instrument in the investigation of mental and behavior disorders. Nevertheless, stress is placed by them on the need for using this diagnostic technique in conjunction with adequate clinical data. The diagnosis of a mental or behavor disorder on the basis of the EEG alone is not justifiable.

Previous investigators, notably Jasper, Pacella et al have investigated the possibilities of the EEG being of use in diagnosing behavior disorders. Obviously, the presence of epilepsy or epileptic equivalents could readily be determined by this method where such condition was latent and was obviously a factor in the misbehavior of the child. The authors of this study, however, felt that psychopathic personalty itself might be investigated by such means. They were confronted immediately with the necessity of defining the term "Psychopathic Personality", the more especially since the great body of psychiatrists and psychologists have been unable to agree among themselves as to just what delimits this term. For purposes of this study, the authors have defined it "as a term applied to various inadequacies or deviations of the personality, other than those with mental deficiency or definite mental diseases which prevent harmonious adaptations of the individual to his environment . . . The defects are in one or more of the instinctive, emotional, conative and characterological aspects of the personality." Three grades of response in the series of forty-four patients studied were designated by the authors under the grades of *Normal, Questionable* and *Abnormal.*

A *normal* pattern was defined by the authors as having no repetitive waves of frequency below eight per second. No special stress is to be placed upon the presence of strong Alpha rhythm. This definition permits a rather wider application of the term normality to the subject than most investigators allow, especially with respect to the Alpha rhythm. The authors are careful to suggest that these findings should be in conformance with similar findings on non-normal adults.

Questionable response shows a pattern in which there were repetitive waves, of eight per second or slower, appearing infrequently in short sequences and of low voltage. Considerable variability in the placement of these waves with respect to the general pattern is one of the main factors in determining the questionability of the pattern itself. The repetitive waves may appear in the absence of any Alpha wave or they may appear between bursts of Alpha activity. Of course, they could appear in one area, completely isolated from the rest of the picture which is of normal appearance. The flexibility and variability of response is perhaps the most notable feature of the pattern.

An *abnormal* pattern, according to the authors, shows frequent bursts of rhythmic activity, slower than eight per second and of a voltage greater than the average voltage of the record. In some cases there are infrequent but protracted bursts of such waves.

The three classifications noted above, in general, meet with technique usually employed by investigators in this field with the single exception mentioned under the normal pattern. They are adequately illustrated in the article by line cuts.

The results of the investigation may be tabulated as follows:

21 Normal	48%
14 Questionable	32%
9 Abnormal	20%

The 52% coming under the questionable and abnormal, the authors are quick to point out, lie very close to the findings of Jasper and others in investigations made of children with abnormal conduct. The authors admit that their series of forty-four is entirely too small to draw conclusions but they feel that the whole study indicates general trends.

In the discussion of the article, the work of Lennox, who suggested in 1942 that there may be a substantial proportion of social misfits such as criminals who would show abnormal EEGs, was men-

tioned. This theory, of course, places criminal behavior definitely upon a physiological rather than a psychogenic basis. It is well known that patients under emotional stress fail to show as great an increase in the percentage of abnormalities as do those of psychopathic personality which, in a way, refutes the Lennox hypothesis. Also it is well known that at least 50% of behavior children are suffering from disorders of behavior in consequence of disorders of cortical function. Suggestion is made that inheritance of cortical dysfunction which may be a delay in development or an encephalopathy is probably at the basis of such abnormal brain patterns. The authors likewise stress the need for relating all of these physiological factors to the environmental and social factors which, however, they feel are of secondary etiological importance.

V. C. B.

Book Reviews

RORSCHACH'S TEST. I. Basic Processes. SAMUEL J. BECK. New York: Grune & Stratton, 1944. Pp. xiii + 223. Price $3.50.

This is primarily a reference book for scoring the Rorschach test. As such it marks a milestone in the development of that method of personality study since, for the first time, there are presented thousands of verbatim individual Rorschach responses with comments as to their proper scoring. The method now becomes, through Beck's open, public discussion of all basic scoring problems of the Rorschach and his numerous illustrative explanations, an objective scientific, technic which gives verifiable and repeatable results and lends itself to qualitative and quantitative standardization. The book can be used as an authoritative final word upon the correct scoring of doubtful responses. Through its careful study, the reader with a previous background in Rorschach experience, can master the processes used to evaluate test responses. The present volume makes no attempt to interpret the significance of patterns of behavior represented by Rorschach symbols or to deal with whole personality structures. It is assumed that these will be covered in a later companion volume.

The author clings tenaciously to the methods of treating test responses developed by Rorschach, Oberholzer, and Levy, and rejects the recent innovations suggested by Klopfer and others. He does introduce one new scoring category which he calls, the organization response and he discards Rorschach's *Originalantwort* as well as some of his own previous English symbols. His former symbol Dr is now Dd while Seq replaces Or and EB is Exp.

The extraordinary number of scored responses have been gathered by Beck from the actual protocols of mentally disturbed adults and children, adults of average to superior intelligence in good mental health, psychoanalytic patients, physically ill patients, acutely disturbed schizophrenic cases, and patients with brain pathology. Thus, practically the entire range of clinical types is represented with the exception of feebleminded and delinquent subjects.

The procedures for administering the Rorschach test which are succinctly outlined in the first chapter are standard enough to insure comparability of results and at the same time flexible enough to allow for adaptation of the procedure to the individual subject. The suggested seating arrangements for the administration of the test follows that of Rorschach himself. The instructions to the subject, the examiner's role in the free association period, card turning, the handling of rejections, withdrawing test cards, the inquiry, dealing with new responses in the inquiry, recording, and possible deviations from the standard procedures, are all explained in easily understandable form so that there can be little doubt as to how a Rorschach examination should be conducted. The "testing the limits" phase which Klopfer adopts as a regular procedure is not used as such by Beck except in unresponsive subjects.

In discussing W, the Whole Response, Beck rejects two types of W responses which are identified and used by Klopfer. These are the incomplete whole and the cut-off whole. He disapproves of Klopfer's D–>W symbol for "a whole tendency" and prefers to classify incomplete wholes and cut-off wholes as either W or D after suitable inquiry enables the examiner to reach a decision. The author does not feel that the need for these new scoring categories is demonstrated and states that the original exposition of W and D by Rorschach covers the situation adequately. However, Klopfer, on page 83 of the "Rorschach Technique" indicates that "Rorschach cited such an incomplete whole in his original delineation of location categories".

A very useful part of the text is the table of most frequent D and Dd selections. All possible location detail responses are numbered, identified and illustrated. The numbering schema is a complete re-

vision of Beck's previous system published in 1937. All of the judgments are based on the frequencies for W, D, and Dd in the ten figures as determined by Dr. Ralph R. Brown. The actual table of the percentage relation of W, D, and Dd responses in the ten figures, to the large total of responses obtained for each figure is presented in the appendix.

The author's discussions of the many scoring problems relating to location of responses fall into five basic considerations: whether to score W or D; whether to score D or Dd; how much of what has been selected is to be scored; whether to score more than once; and whether to score at all. These are concretely and masterfully presented and the reader who follows painstakingly, the actual examples and the thinking behind the scoring of each sample, acquires the equivalent of many years of experience. Four varieties of reactions to the white space are described as compared with Klopfer's three ways in which the white space can be used as the area for a concept formation.

An original contribution is Beck's introduction and description of the organization activity score or Z. He developed this concept on the basis of his investigation of configurational tendencies in 2,215 responses obtained from a group of very superior persons. Four kinds of organization occurred with sufficient frequency to permit of establishing a sigma value for each kind in each of the ten Rorschach figures. These were wholes, adjacent details seen in relation to each other, distant details so seen, and white spaces organized with filled-in elements. According to Beck, "a response is scored *organization* or Z, when two or more portions of the figure are seen in relation to one another, and when the meaning perceived in the combination, or in any of the component portions, obtains only from the fact of this organization". His nine rules for scoring Z leave no doubt as to when this score is applicable.

Beck's discussions and examples of the approach and sequence scores, movement, color, light-determined, form and popular responses, content scoring, diverse determinants, and experience balance, all leave nothing to be desired. He makes perfectly clear the principles involved in each of these types of scoring. He does raise some unsettled points and suggests lines of research to help clarify them. For example, how much overlapping of physiologic process is there between the two variables of approach and sequence? The two activities need to be isolated from each other and possible common factors established.

It is in the discussion of the movement response, M, that Beck takes sharpest issue with other scoring as it has been done in the current literature. He points out that error in identifying M leads to serious mistakes in personality interpretation. He considers it the "nuclear point about which has sprouted much of the subjectivism charged to the test". The errors, as Beck sees them, are mostly in the direction of scoring M where there is none. According to Beck and all Rorschach-Oberholzer disciples, M is found only in human content and consists of human activity. In this connection, it is interesting to note that Klopfer recognizes animal and animal-like action and scores it FM. Beck frankly admits that his scoring of M responses is based upon faith in Rorschach and Oberholzer rather than upon conviction resulting from validated findings.

The table listing varieties of form responses and their location for all ten figures occupies 33 pages but proves to be a useful index for classifying such responses. Almost any kind of F response can be found in this table. The presentation of three complete records help integrate the scoring of a complete protocol but contrasts sharply wth Beck's 59 seconds in his *Introduction to the Rorschach Method*. The book contains only a brief bibliography of 13 references and does not attempt to review the extensive literature on the Rorschach.

In summary, the present volume is considered indispensable to most users of the Rorschach technic because of its concreteness, its unmistakable expertness, and its many clarifying hints on scoring doubtful responses. It will serve to make of every Rorschach administrator, a competent

scorer, thus enabling him to fulfill the most important prerequisite to expert interpretation. The volume will almost certainly be consulted constantly by psychologists and psychiatrists in their day-to-day work with the Rorschach. It is however unfortunate that each new book on the Rorschach utilizes some unique symbols not agreed upon by other authors, with equal authority, thus confusing the students of the method. This reviewer makes a plea for uniformity of symbols and suggests Beck's volume as the basis for establishing such uniformity.

Samuel B. Kutash
Woodbourne, N. Y.

YOUNG OFFENDERS—AN ENQUIRY INTO JUVENILE DELINQUENCY. A. M. CARR-SAUNDERS, HERMANN MANNHEIM, and E. C. RHODES. American edition. New York: MacMillan Company, x plus 168 pp., 1944. $1.75.

This book is the American edition published by the MacMillan Company in March of this year. It had been published last year at the University Press in Cambridge, England. Because of the steady increase in juvenile delinquency in this country under wartime conditions and the similarity of conditions in cities of this country and England, it was felt that the American edition should be produced.

Mannheim, Lecturer in Criminology at the London School of Economics, prepared the first two chapters entitled "Previous Investigations" and "Trends in the Incidence of Juvenile Delinquency" and the Appendix. Rhodes, Reader in Statistics at the same School presents "The Present Investigation," while Mr. A. M. Carr-Saunders, Director of the London School of Economics, had charge of the planning and general supervision of the work of instituting and investigation of the problem of juvenile crime under the general direction of the Home Secretary.

This study uses the statistical method to show the relationship between environmental conditions and anti-social behavior. Its summary of previous investigations in Britain from 1816 (*Report on the Committee for Investigating the Causes for the Alarming Increase of Juvenile Delinquency in the Metropolis*) during the Napoleonic Wars through the works of Morrison, Leeson, Burt, Chinn, Goring and Pearson, etc., coupled with sundry reports during the period, is especially valuable to those interested in the historicity of studies in criminal statistics.

Delinquent boys (1,000) who appeared before the seven juvenile courts of London from October 1, 1938, were matched with an equal number of non-delinquents from the same area. Delinquent boys from provincial towns were chosen at a later date and matched in their own settings. Altogether there were 1953 delinquents and 1970 matched non-delinquents. The latter were chosen by the head teachers of the schools who were asked to pick out boys of roughly the same age level and who could be considered a mate to the former. These groups were broken into four sections: (1) those of normal families with normal parents and the children living at home, (2) those who in addition to being in section one had relatives or lodgers in the home, (3) other families with two heads (male and female) in the household, *e.g.* aunt and uncle of the case, or stepfather and mother of the case, and, (4) families with one head only, *e.g.* widowed mother, and children, and others. While this investigation was first planned for London only, it was extended to Manchester, Leeds, Sheffield, Hull, Nottingham, and Cardiff. It was found that in London, 71.4 per cent of the delinquents came from the first section as did 79.7 per cent of the delinquents and 79.8 per cent of the controls were also in this section. Four other factors in the normal family of both delinquents and non-delinquents were studied: health of the parents, their habits, attitudes toward each other, and, toward the subject. The homes that were considered structurally and psychologically normal were investigated further. Factors related to delinquency in these homes were: overcrowding irregularity of father's income, school retardation leisure time activities limited, and other delinquents in the household. The age of highest delin-

quency was found to be 13, however, "it is difficult to decide whether the greater number of delinquents aged 13 is due to an increased tendency to naughtiness at that age, or merely due to the fact that there are more boys of that age." Juvenile crimes are committed more in gangs than alone (London, 707 gang offenses as opposed to 281 alone; all provincial towns, 712 gang and 251 alone). The types of crime and incidence included: "for ages 8-13 about 35 to 40 per cent of the arrests are for simple and minor larcenies, about 10 per cent for larceny from shops and stalls, about 12 or 13 per cent for larceny from vehicles, and about 10 per cent for larceny of pedal cycles. About 70 per cent of the arrests are thus accounted for. An important crime, shopbreaking, shows a gradual diminishing percentage of about 20 at age 8 to 15 at age 13. Larceny from automatic machines and meters shows a gradually increasing percentage from about 3 to 7. At age 16, the proportions have become different. The simple and minor larcenies now account for about 25 per cent of the crimes, other indictable offenses account for 15 per cent, larceny of motor vehicles for about 11 per cent. There is obviously a difference in character between the manifestation of delinquency at ages 8-13 from that at 16." (p. 125-126).

This statistical study into familial relationship to delinquency provides additional categories previously not considered in crime causation. It shall prove of value to not only the layman interested in its problem, but to the penologist, criminologist, judges, welfare workers, as well as those in this particular area of research.

Chester D. Owens
Woodbourne, N. Y.

STREET CORNER SOCIETY. WILLIAM FOOTE WHITE. Chicago: University of Chicago. xii plus 284 pp. 1943. $3.00.

Street Corner Society is one of the Sociological Series books published by the University of Chicago. This series, it will be recalled, includes such other titles as: *The Professional Thief* (Sutherland), *Family Disorganization* (Mowrer), *The Gang* (Thrasher), *Vice in Chicago*, (Reckless), *Taxi-Dance Hall* (Cressey), *Gold Coast and the Slum* (Zorbaugh), etc. Whyte, former acting chairman of the Department of Anthropology and assistant professor of Sociology at the University of Oklahoma, spent three and a half years in "Cornerville" the Italian Community of "Eastern City" in intimate association with the residents of the area to gather the data he presents.

The book is written in an informal manner using the "own story" technique and observation in analysis of an area. It is reminiscent of Shaw's *Jack Roller* or his *Natural History of a Delinquent Career* in which this methodology was applied to individual cases.

Inasmuch as some illegal activities were present in Cornerville, the author had to give some reason for his presence in the community lest he be considered a G-man. At first, he employed the expedient of stating he was studying the history of Cornerville since the beginning of Italian migration, but he found that this method did not yield the type of information he wished. In each group he found a leader whose authority was respected. With the leader's assistance he could accomplish much, without it little. Therefore, he spent considerable time playing pool or cards, bowling, eating and drinking, etc., with the leaders to obtain their support. That he did so over the period of time is borne out by his being accepted into membership in several Italian-American social clubs. The leaders also helped by observing and discussing situations with him in which he was interested.

The social sructure of several social clubs (The Nortons, Shelby Street Boys, Community club, etc.) presents an insight into the social strata of the community, attitudes among group members, attitudes toward other groups, group loyalty, political activities, etc. The rise of certain boys through high school and college and later success in the community is sharply limned against the background of those

boys who were true gang members, sharing their wealth and possessions to the extent that the cost of further education was not within their grasp. The activities of corner boys and college boys are thus sharply focused. Considerable discussion is given to the social structure of male clubs such as *The Sunsets*, *The Nortons*, *The Community Club* and their inter-relationships, community interests, and relationships with *The Aphrodites* (working Italian girl group) and the *Italian Junior League* (Italian debs group). The rise and fall of leaders, method of subordinating members to the leaders, disintegration and re-organization of groups are presented clearly.

Other aspects of the community are considered: the function of the Settlement House, attitudes of its employees and its clientele, rackets in the community, relations of racketeers to the police, politics and the political careers of Cornerville boys, the effect of marriage on the memberships in groups, the nature of political obligations in the community, and the problem which Cornerville presents. The latter is most important. This is the significant residue of the synthetic picture presented. It is summarized thus, "Not until outsiders are prepared to recognize some of the same people that Cornerville people recognize as leaders will they be able to deal with the actual social structure and bring about significant changes in Cornerville life . . . When an Italian boy sees that none of his own people have the good jobs (settlement workers, teachers, policemen, etc.), why should be think he is as good as the Irish or the Yankees? It makes him feel inferior."

The book is illustrated with interactionary charts with the relative position of the observer indicated. More of these patterned along the lines of Moreno's "psychological geography of a community" in his sundry sociometric studies would enhance the book. In addition, definite proposals for the solutions of the problems of Cornerville with their pro's and con's would leave this reviewer with a sense of fine accomplshment in the social development of the community. One feels, after putting aside a study of this type, that we do have a better understanding of the humans of an area as individuals, but the solution of their problems remains in a doubtful state. Whyte presents his data interestingly and informatively. We know Doc, Long John, Chick, Mike, and the others and understand their social plight. How to elevate the "corner" boys in social and economic strata is the problem.

(*See also*: *Slum Sex Code*. W. F. Whyte. Vol. V, p 416. *J. Crim. Psychopath*).

Chester D. Owens,
Woodburne, N. Y.

CONDITIONED ENVIRONMENT IN CASE WORK TREATMENT. Monograph. Jewish Board of Guardians. June 1944. 41 pp. 50 cents.

This monograph contains five articles written by the members of the staff of the Jewish Board of Guardians during 1941 to 1943. They cover the experiences of the agency in the treatment of children at Hawthorne-Cedar Knolls School and the Lavanburg Corner House.

The Introduction by Herschel Alt, Executive Director, indicates that the type and quality of the care which institutions offered delinquent children reflected the changing concepts and theories of education, penology, and the general social attitudes toward crime and delinquency. Educational values and the development of strong character traits have supplanted rigid discipline and hard work as the rehabilitative measures of institutions. The individualization of the child in the terms of his physical, intellectual, and emotional needs has recast institutional programs of rehabilitation. Where case work is well developed, a continuous relationship to the child while in the institution and his post institutional life is maintained. The development of a therapeutic environment for children includes a determination of the needs of the types of children to be served and the treatment goals to be accomplished. The staff at the Hawthorne-Cedar Knolls school has three functional departments: Child Guidance, Education,

and Cottage parents. The selection, training, supervision and satisfactory working conditions of the Staff are important factors in the attitudes and capacities which the Staff brings to the job. Another important factor is the total of the community attitudes toward children including conventions, sanctions and taboos. These not only need to be taught but must be intuitively felt by the Staff. One of the most potent factors in safeguarding the treatment is the example set by members of the staff in key positions. The children, too, must identify themselves with the goals set for them in order to set up an efficacious rehabilitative program. The Superintendent's role is also important: "he is the one person who should have definite conviction about treatment goals of the institution and the ways these can be accomplished."

In *An Integrated Approach to Child Guidance* by Frederika Neumann we learn that the Jewish Board of Guardians is a child guidance bureau whose function is to study and treat children presenting problems of behavior: those disorders which have not become a part of the personality sttructure but require treatment of the parent-child relationship, those disorders which appear to be a fixed part of the personalty structure, and which require direct individual treatment for their resolution, and, disorders such as psychoneuroses and pre-psychotic conditions.

The Jewish Board of Guardians has the following services: child guidance department, volunteer department, group therapy department, and the Cedar Knolls school. These do not form a child guidance clinic but may be considered a clinically oriented social agency. The relationship of the problems of these children to psychiatry is a fundamental one. The purpose of the procedures and educational program is to assure that there is a psychiatric orientation in every phase of the activity. The objective of the agency is a synthesis of the many specialists for the purpose of a well-rounded child guidance service.

It is necessary to determine the nature of the problem, establish a tentative diagnosis, and determine treatment. This includes the ability and wish of the child and parent to avail themselves of the services. Hence the intake worker must be able to recognize and work with resistances. During this process, the intake worker must recognize if the child predominantly needs interview treatment, the services of a volunteer Big Brother or Sister, or gives indications of relating better to group rather than individual help. It may be that the case can not be helped in his own home but should have treatment in the controlled environment of Cedar-Knolls. In all cases in the city office the same essential approach is used: a period of exploratory contact and study, culminating in the sixth week after the assignment (after about four interviews with the child and about the same number with the parents) in an initial conference between psychiatrist, social worker and supervisor. This conference is to determine diagnosis and plan treatment. Other diagnostic services may be used prior to this conference: various psychological tests, including Rorschach, and physical examination; or the need for diagnostic services or need for treatment by other departments may be indicated by this conference. Continued collaboraton is evidenced by the routine treatment conference on every case at least every six months after the initial conference. For some years a seminar on diagnosis led by a psychiatrist for all social workers in all departments in their first year of service and for the social work students has been held. This is designed to give them a dynamic concept of the meaning of the psychiatric categories in use in the agency. Another committee on group treatment is also in existence.

Benjamin Levy's description of the *Hawthorne-Cedar Knolls School* and its environment is given under this title. A pre-classification conference is held on a case eighteen days after admission. His background is summarized, his behavior as observed by staff members is discussed, the psychiatrist indicates diagnosis, a cottage is chosen according to his size, age, intellect, social adjustment, emotional state, etc. The problem syndromes vary from the extremely withdrawn to the hyperag-

gressive with specific symptoms such as: truancy, incorrigibility, running away, stealing, sexual misbehavior, negativism, and withdrawal. They range in age from 8½ to 18 years. The cases are received from three general sources: The Court, Department of Welfare, and private arrangements through some social agency. This paper stresses the extra-mural functions of different individuals in the School environment in the treatment program. A teacher may be also a Big Brother, a plumber may be a father surrogate as well as a trade teacher, the case worker may limit his treatment to doing what a Big Brther might do, other boys have been used directly or indirectly in the handling of a specific problem, the psychologist has served as a teacher and father substitute, male case workers have been used by the women workers in the indirect treatment of a certain girl, etc. Four factors are involved: the needs of the individual child, the ingenuity of the case worker, the understanding of the administration and the flexibility of personnel.

The Cottage Parent in an Institution for Delinquent Children is presented by Morris F. Mayer. While the viewpoint of teachers social workers, psychiatrists, etc., for their separate treatment processes has been presented, the cottage parent is usually unable to do so because of inability to convey their experiences to newcomers. They have proven to be eager to get definitions of their functions, yet, at the same time, they have been concerned lest such definitions might put the job above their personal capacities.

This paper is concerned with the different phases of the functions of cottage parents. The cottage parents admitted in discussion that their objectives in taking a job offering little private life were: need of a job during time of economic duress, some had found that the economic social protection of an institutional job was a good solution to their economic problems, then when the depression was over they felt too adjusted to the job, too institutionalized, to leave, they felt they had something to offer the children, they had gathered experience which was good only on this particular job, the job provided an opportunity to satisfy their need for power and to dominate a situation. Personal pre-requisites for every child-care worker are: a certain balance of personality, an interest in and liking for children, a belief that human beinngs can be educated. Three phases of the cottage parent's development on the job include: the phase of identification, the phase of leadership, and the phase of guidance. To produce such development in the untrained child-care worker adequate supervision and training must be provided the worker. A thoroughly planned trained program for these workers should be provided.

Irving Ryckoff presents *The Treatment of Parolees.* Through the use of a case history he points out that the authority with which the parole officer was able to handle a situation emerged from his knowledge of the case's dependent patterns and from his awareness that the boy was becoming dependent on the parole officers. The therapeutc possibilities of the case were strengthened through this knowledge.

The appendix describes the Hawthorne-Cedar Knolls School—its location, the cottage plan, academic and vocational training, religious education, medical service, the child guidance clinic, community life, admission, fees, parole procedures, and report of the committee on admissions. There is also presented information on the Lavanburg Corner House.

Chester D. Owens
Woodbourne, N. Y.

JAILS—CARE AND TREATMENT OF MISDEMEANANT PRISONERS IN THE UNITED STATES. LOUIS N. ROBINSON. Philadelphia: John C. Winston Co., vi plus 295 pp., 1944, $3.00.

This book is an exhaustive survey of the jail and related problems by the former Chairman of the Pennsylvania Board of Parole who had also served as Chairman of the Federal Prison Industries Reorganization Administration, Member of the Board of the Eastern Penitentiary of Pennsylvania, Investigator for the Nation-

al Crime Commission, Chairman of the Pennsylvania Committee on Penal Affairs, *etc.* Robinson is also the well-known author of *History and Organization of Criminal Statistics in the United States*, *Penology in the United States*, and, *Should Prisoners Work.*

This work was begun in 1935 and completed in 1943. Because of extra official duties, Robinson took longer than expected to finish the work. Through the media of questionnaire and personal visit he obtained data on such chapterial divisions as: Conditions and Practices in Jail, What has Produced the Jail Problem, Character of Inmates, Houses of Correction and Workhouses, County Misdemeanants, Road Work for Misdemeanants, County and Municipal Prison Farms, Special Institutions for Women Misdemeanants, State Care for Male Misdemeanant Prisoners, Private Agencies in the Prison Field, Federal Misdemeanants, Alcoholics, Conclusions.

Robinson points out that there are roughly four thousand jails while there are less than 150 state prisons and reformatories and Federal institutions in the United States. Jails in 1933 had 608,484 inmates, while the Federal census for 1937 showed 54,468 in the same year (1933) in the state prisons and reformatories and Federal institutions. Because of the short-term sentences of misdemeanants little effort is made toward the physical, mental, social, or vocational rehabilitation of these inmates. Robinson's thesis is that a radical solution to the jail problem must be sought. Methods of improvement are suggested as follows: *to keep people out of jail*—release on their own recognizance, payment of fines in instalments, probation, reform of the justices of the peace, abolition of turnkey fees, abolition of the fee system of compensation for feeding the prisoners, abolition of fee system of compensating constable and deputy sheriffs; *substitution of other local institutions for the jail type of offender*—houses of correction and workhouses, penitentiaries county road camps, county and city farms, *to improve the jail itself*—new buildings, repair and modernization of old buildings, development in architecture and in building construction, change in location from city to country, separate buildings for women, separate building for convicted prisoners, location near other city or county institutions where prisoners may be employed; *to improve the management of the jail*—state supervision, ousting the sheriff from control, civil service, provision for teachers by Federal and city authorities, indeterminate sentence, and parole; *state care of misdemeanants* — state industrial farm for sentenced men, sending women to the state reformatory for women, transfer to state institutions for the feebleminded, defective delinquents and alcoholics, and state road camps.

The book is well-indexed, informative, and a piece of scholarly research in an area much needed in the American penological scene. The summations of materials from all states in the Union presents a picture of the best, as well as the worst, conditions. The suggestions for reform are soundly scientific. If the accomplishment of this book is but one thing: legal provision for a state commission in every state to inspect the jails (now existant in only four states, Indiana, Alabama, New Jersey, and New York) with power to close them if they fail to meet certain standards, the book will have served a noble purpose. The use of week-end sentences is not treated in the book. A discussion of this expedient would be suitable under the recommendations.

Chester D. Owens,

Woodbourne, N. Y.